UNICARE USER'S MANUAL
FOR
MENTAL HEALTH CLINICIANS

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INTRODUCTION

Unicare is a clinical documentation software system that is used by the Mental Health Department of Santa Clara County Health and Hospital System. All services, progress notes and the Initial, Update and Psychiatric Assessments are entered into Unicare by mental health providers. The Department of Alcohol and Drug Services (DADS) also uses Unicare.

Unicare was implemented on October 1, 2003. It replaced an application called OSCAR, where all of the clinical documentation was handwritten.

The Unicare User's Manual for Mental Health Clinicians guides the provider to navigate the Unicare screens, client searches, recording client services, entering and printing progress notes and assessments, and creating reports. This Manual also shows the collaboration between the clinical and clerical staff regarding how client information is entered into Unicare. Eleven appendices are included:

- Appendix A contains information about Client and Service Information (CSI) and General Medical Condition Summary Codes for Axis III
- Appendix B contains a CSI dictionary for Place of Service
- Appendix C contains CSI dictionaries for Evidence-Based Practices and Service Strategies
- Appendix D has instructions for Auto Refresh
- Appendix E has the Voids Policies and Procedures (P&P) section 635
- Appendix F has the instructions to use Bookmark in Navigator
- Appendix G shows Another Method for Finding a Client
- Appendix H continues with Finding Planned Services
- Appendix I finishes with Caseload Provider on Tree

Before logging into Unicare, a user account must be set up for system security and client confidentiality. You and your clinical supervisor should coordinate with your office supervisor regarding the necessary paperwork to receive access and authorization to Unicare. This paperwork includes:

1. Code of Conduct form – P&P 107, Attachment B
2. Personal Action Request County/Contract Agency (PARCCA) form – P&P 504, Attachment A
3. Username Request form – P&P 601, Attachment A
4. Oath of Confidentiality form – P&P 601, Attachment B

Refer to the Mental Health Department's Policy and Procedure Manual for details.

In this manual, providers are defined as those individuals who provide direct mental health services to clients. A provider can be a clinical social worker, marriage and family therapist, rehabilitation counselor, intern or trainee, psychiatrist, nurse, pharmacist, case manager and others.

CLIENT RECORDS AND UNICARE ENTRY WORKFLOW

Client information is entered into Unicare by both clinical and clerical staff. The following is an example of which staff are responsible for what paperwork and data input. The following Intake/Treatment/Discharge review is County-specific and general in nature. Your particular clinic procedures could be different.

Intake

When a client first enters a clinic to begin receiving mental health services, they are interviewed by a clerical staff person for demographic and insurance information. The clerical staff then registers the client into the Unicare system. The client then meets with a case manager to begin the assessment process. The case manager will fill out a Client Cost Center Open and Discharge form and then give it to the clerical staff who enters this information into Unicare.

Note: There are now two ways to record Axis III diagnoses. See Appendix A.

Treatment

Progress notes are entered into Unicare only by providers. If the client's clinical information changes, such as diagnosis or trauma information or the case is transferred to another clinician in the same program, then a case manager needs to fill out another Open/Discharge form and give it to the clerical staff for data entry. If the client's demographic information changes, then the clerical staff needs to be informed so that they can make the changes in Unicare.

Discharge

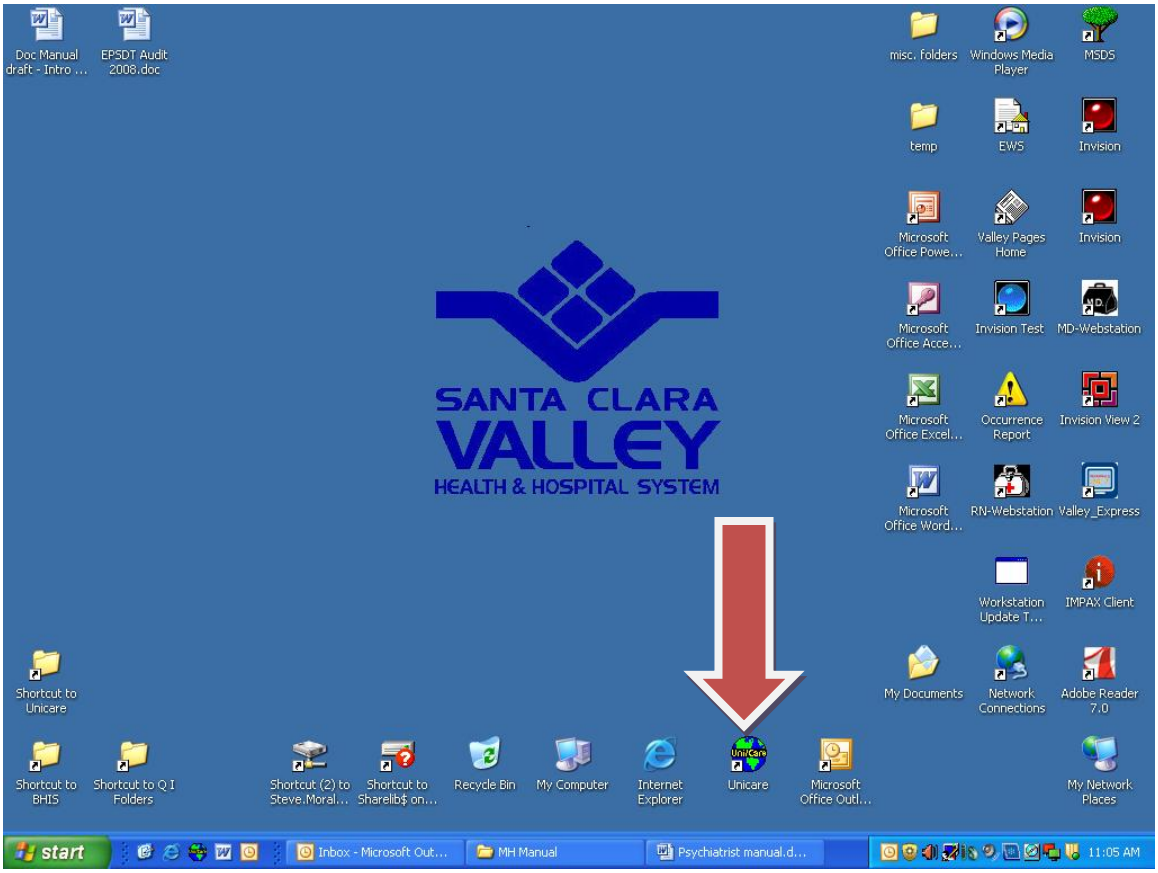
When a client is discharged from a program (cost center), the case manager again fills out the Discharge Coding form and the Open/Discharge form to close the case. These are then given to the clerical staff who will enter this information into Unicare to complete the Discharge process.

Call Center

Many clients enter our mental health system by first contacting the Call Center at 1.800.704.0900. Call Center staff fill out a MH Referral form in Unicare, which is used by a clinic to contact the new client to set up an intake appointment. If needed, a clinician or clerical staff could access the MH Referral form by clicking on the User Defined Data (UDD) tab in the Profile of Client screen for that particular client and opening the MH Referral.

LOGGING INTO UNICARE

From the desktop, double-click on the **Unicare** icon. You can also right-click and choose Open.



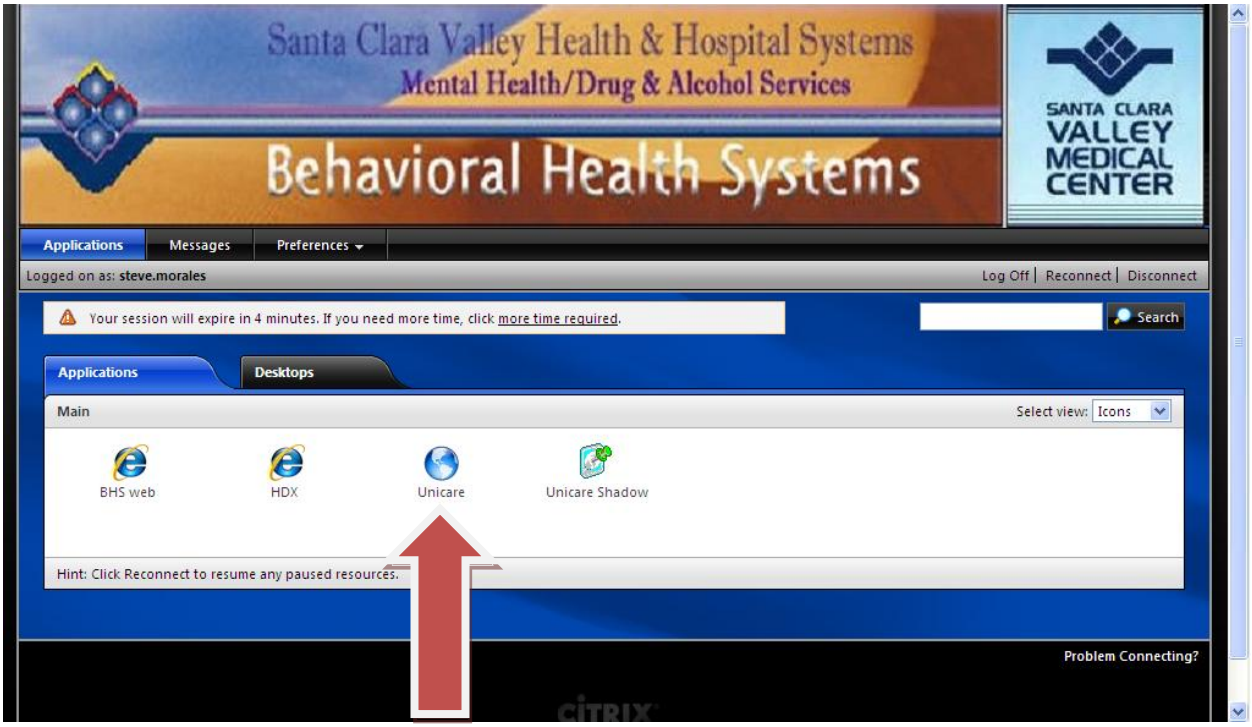
Enter your User name and Password, then click Log On.

Note: For County users, this is the same user name and password that you use to logon to your computer.

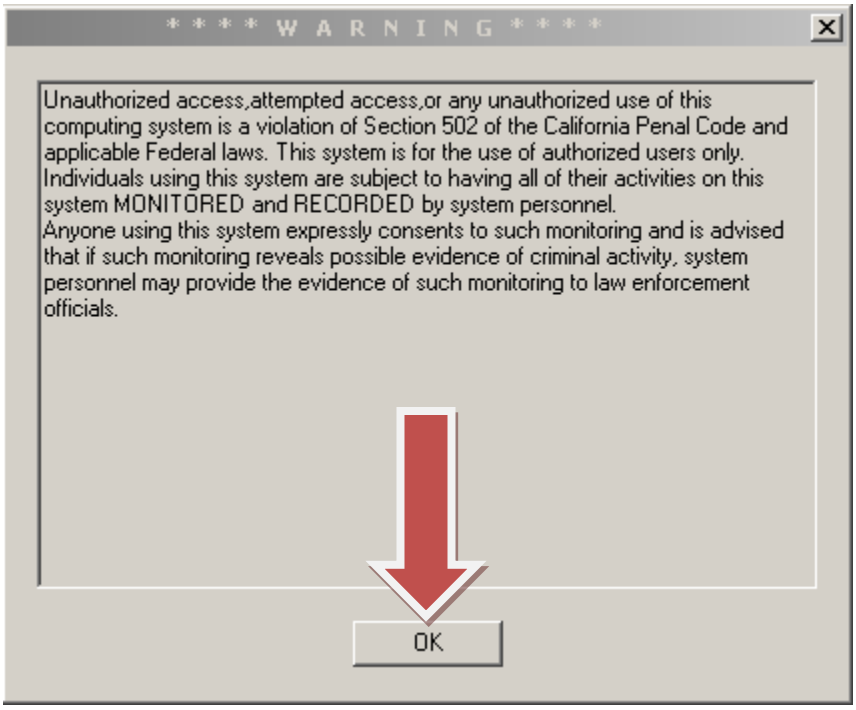
Note: You get three chances to enter your Username and Password. If you fail to log on after three times, you will be locked out. If this occurs, call the Service Desk at 885.5300 and tell them that you need your Unicare password reset. You will need your Unicare ID, which can be found at the top of the Who Am I report.

Hint: If you fail to log in properly after two attempts, close this screen and start over. Then you will be given three new chances and you will not have to call the Service Desk.

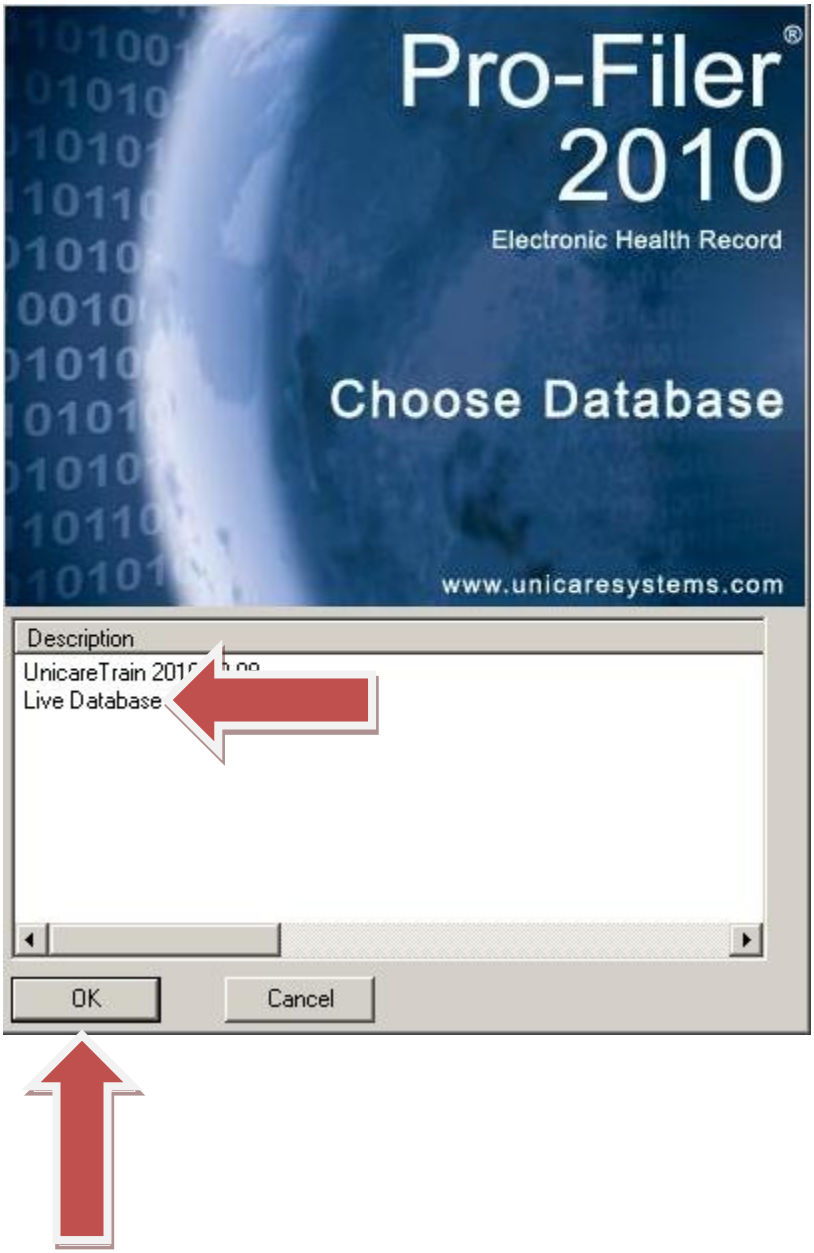
Click on the **Unicare** icon.



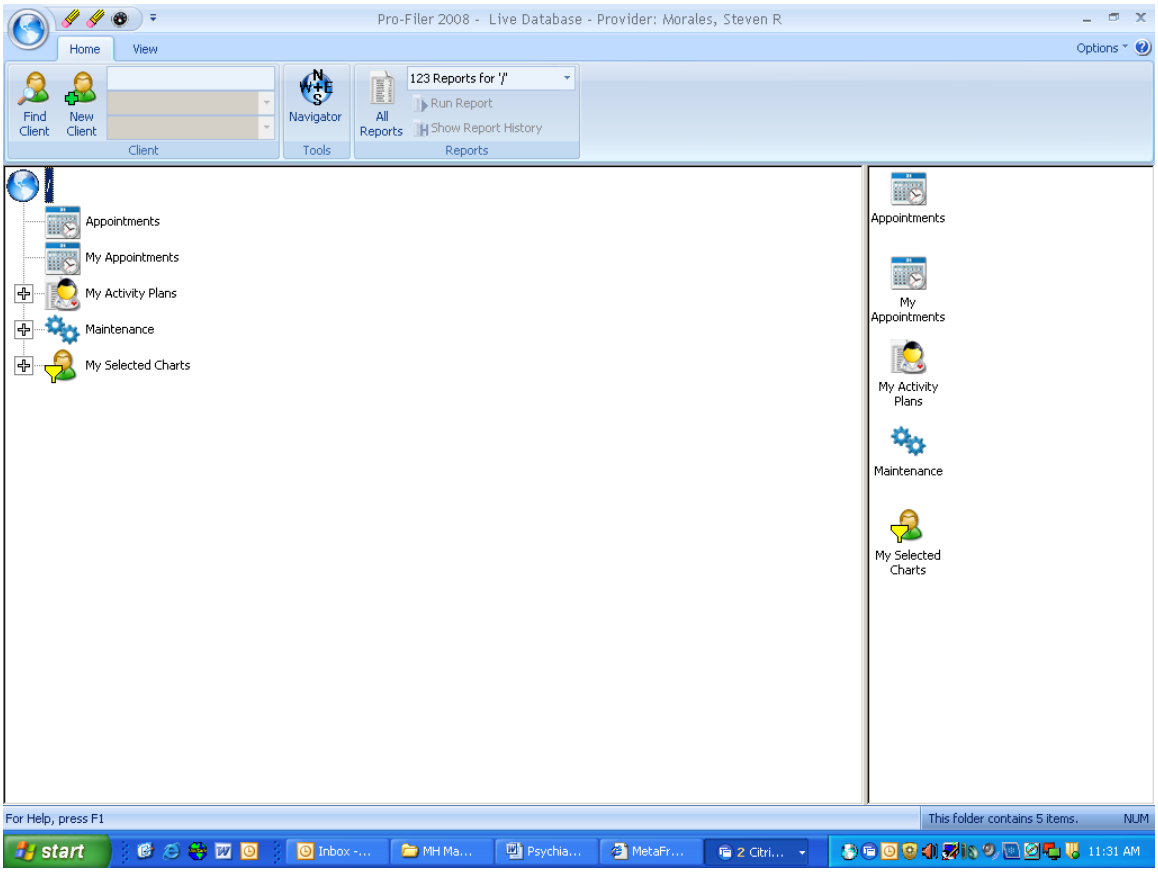
Click **OK**. This message is required of all applications so if someone was to hack into the system, they would be knowingly violating some laws.


* * * * W A R N I N G * * * *
Unauthorized access,attempted access,or any unauthorized use of this computing system is a violation of Section 502 of the California Penal Code and applicable Federal laws. This system is for the use of authorized users only. Individuals using this system are subject to having all of their activities on this system MONITORED and RECORDED by system personnel.
Anyone using this system expressly consents to such monitoring and is advised that if such monitoring reveals possible evidence of criminal activity, system personnel may provide the evidence of such monitoring to law enforcement officials.
OK

Click **Live Database** then click **OK**.

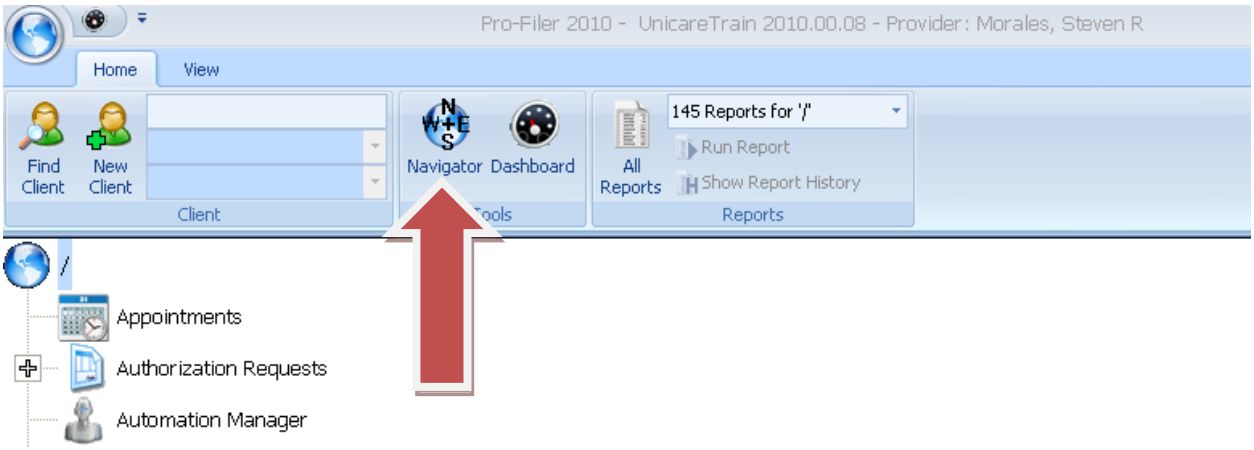


The Tree View is now displayed.



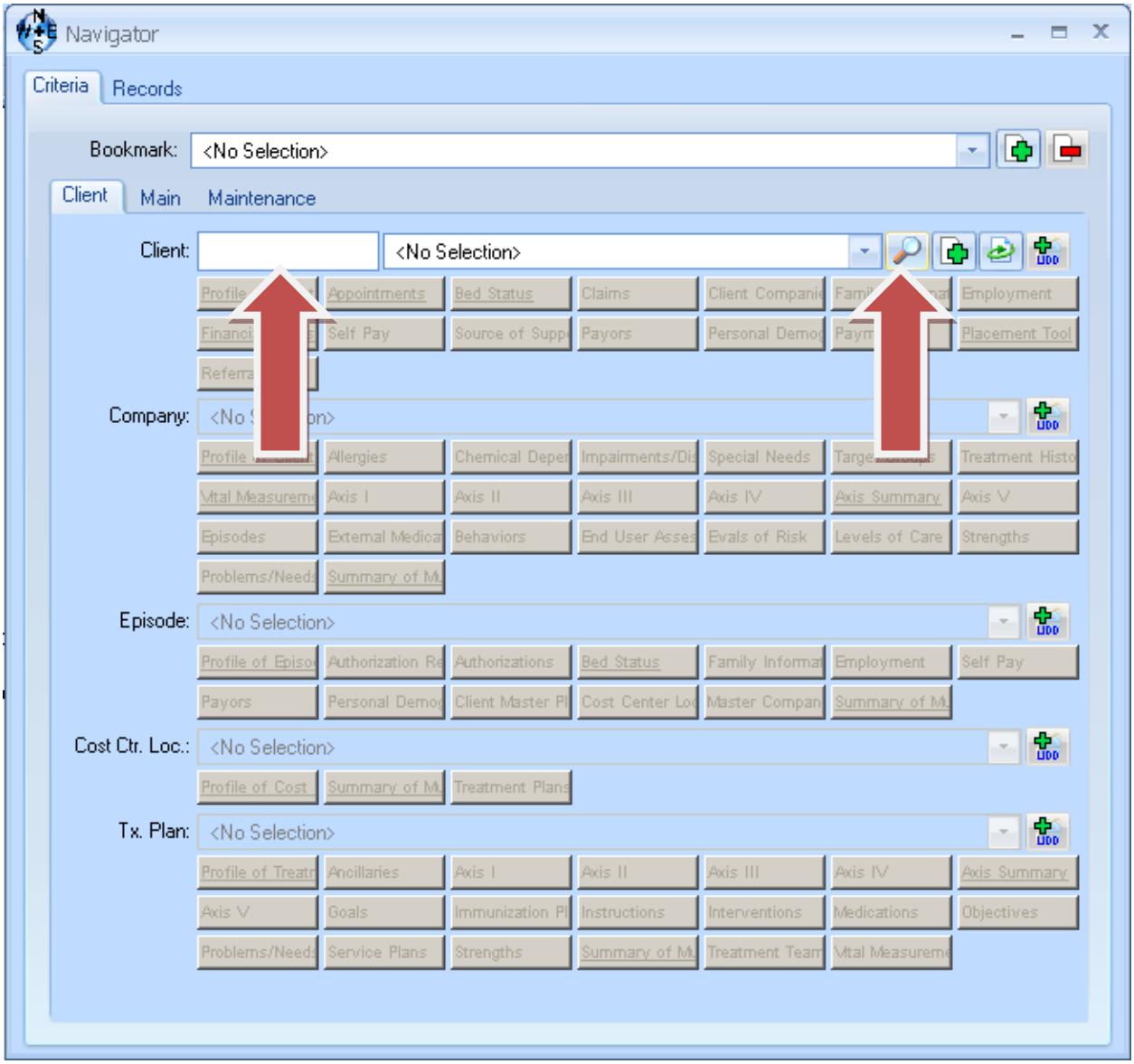
USING NAVIGATOR

To have the easiest access to all of your clients, use Navigator icon. Click on the **Navigator** icon.

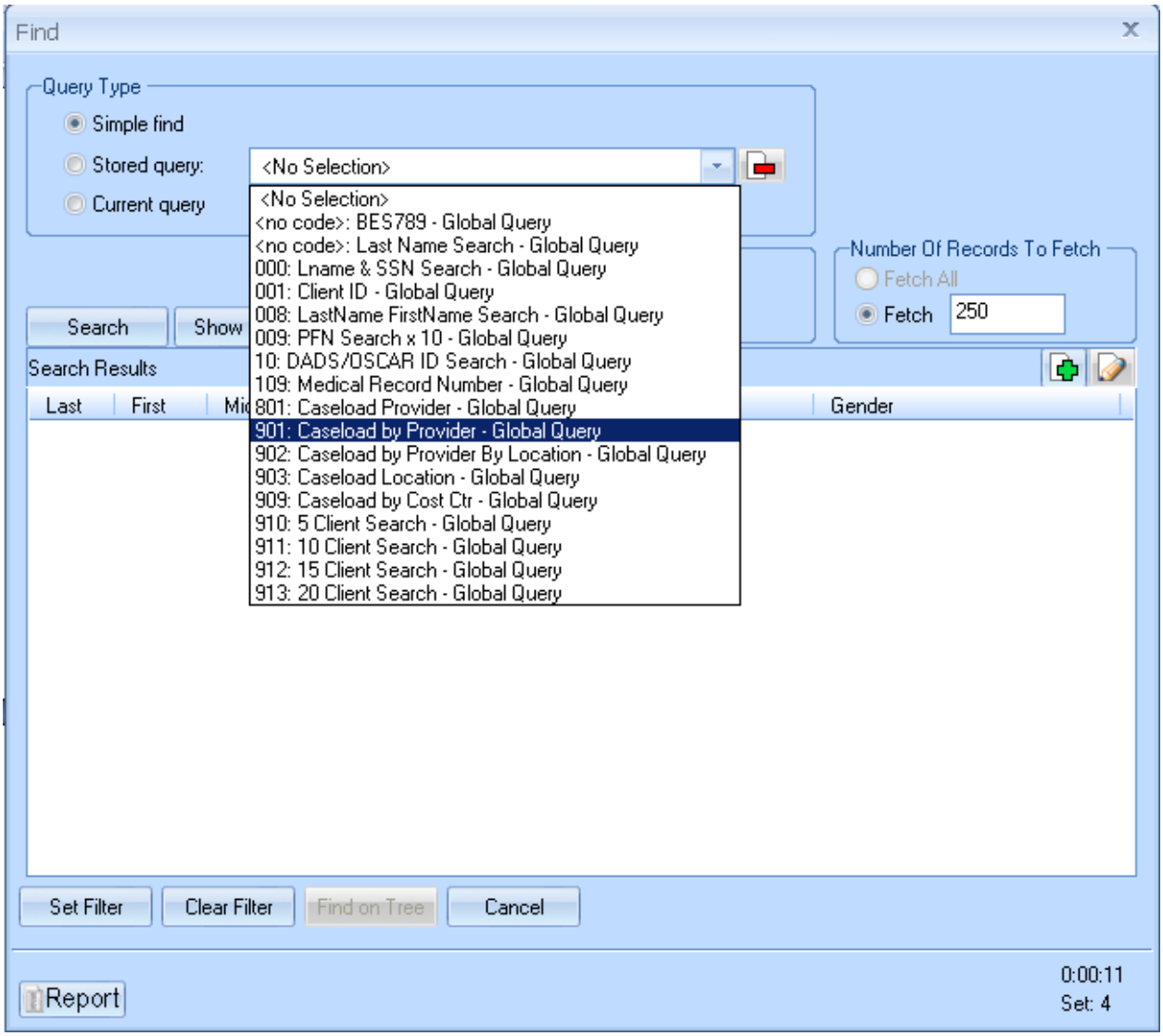


Click the **Find Client** icon (magnifying glass).

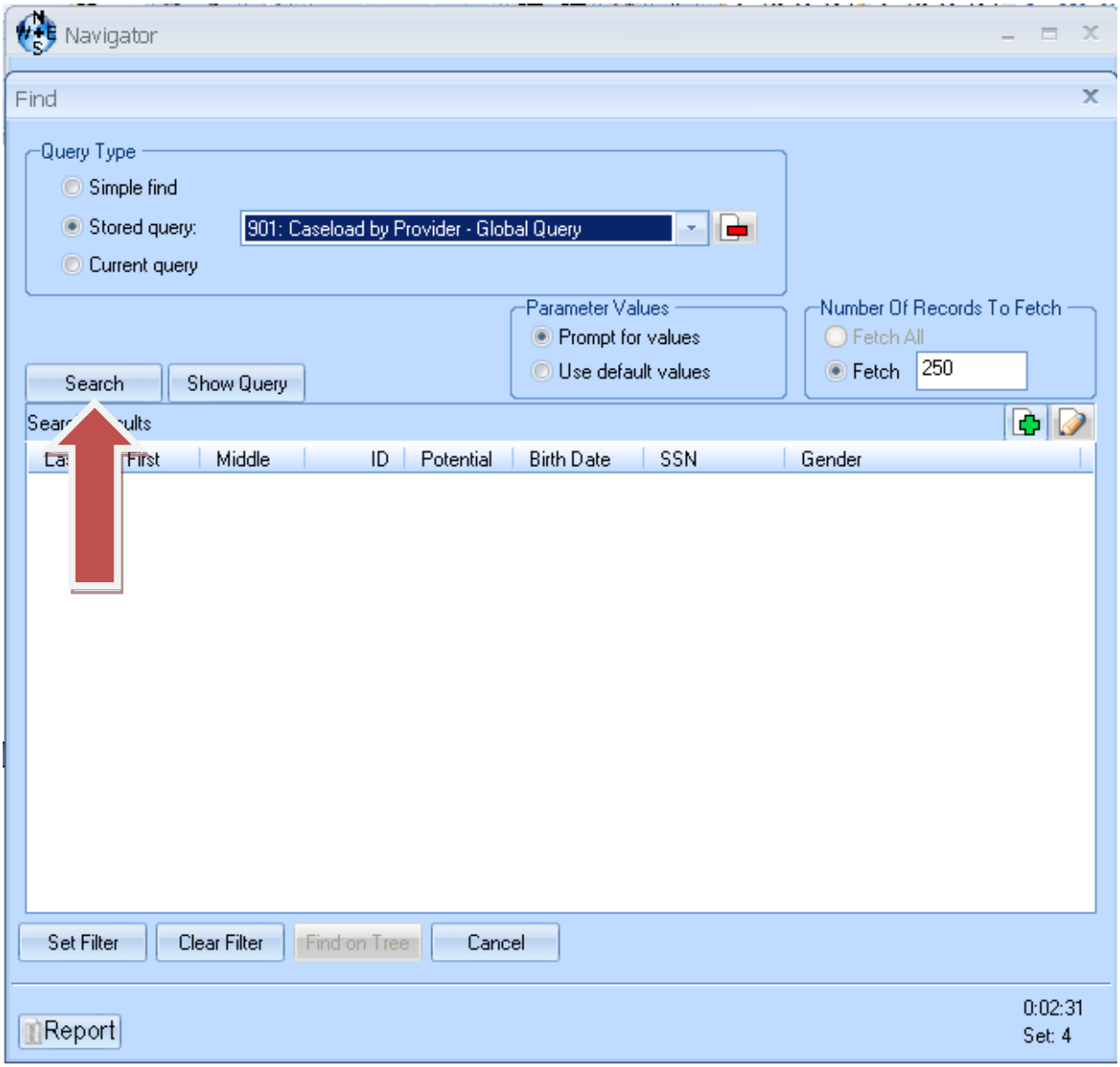
Note: If you want to locate only one client, type in their Unicare number in the Client field and click either the Find Client icon (magnifying glass) or hit the Tab key on your keyboard.



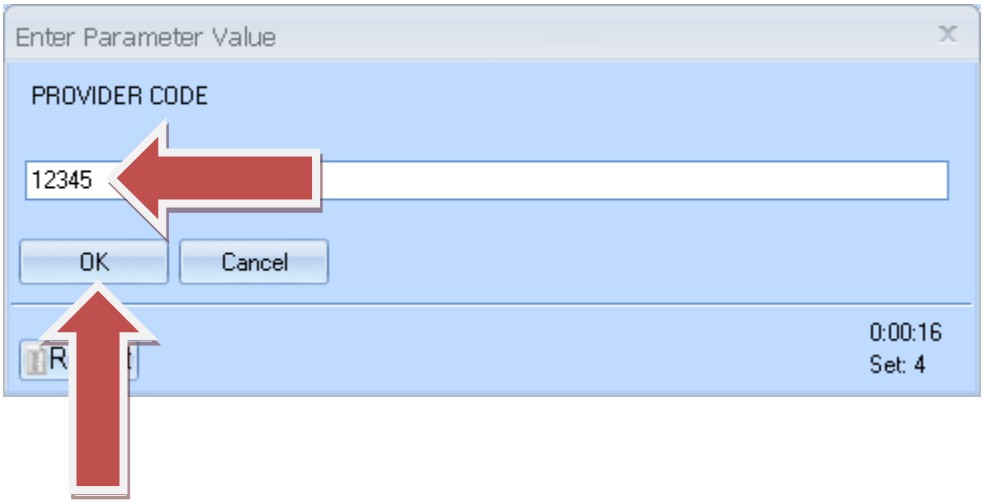
Click in the dropdown field next to Stored query and choose **901: Caseload by Provider – Global Query**.


Find
Query Type
Simple find
Stored query:
Current query
<No Selection>
<No Selection>
<no code>: BES789 - Global Query
<no code>: Last Name Search - Global Query
000: Lname & SSN Search - Global Query
001: Client ID - Global Query
008: LastName FirstName Search - Global Query
009: PFN Search x 10 - Global Query
10: DADS/OSCAR ID Search - Global Query
109: Medical Record Number - Global Query
801: Caseload Provider - Global Query
901: Caseload by Provider - Global Query
902: Caseload by Provider By Location - Global Query
903: Caseload Location - Global Query
909: Caseload by Cost Ctr - Global Query
910: 5 Client Search - Global Query
911: 10 Client Search - Global Query
912: 15 Client Search - Global Query
913: 20 Client Search - Global Query
Number Of Records To Fetch
Fetch All
Fetch
250
Search
Show
Search Results
Last
First
Gender
Set Filter
Clear Filter
Find on Tree
Cancel
Report
0:00:11
Set: 4

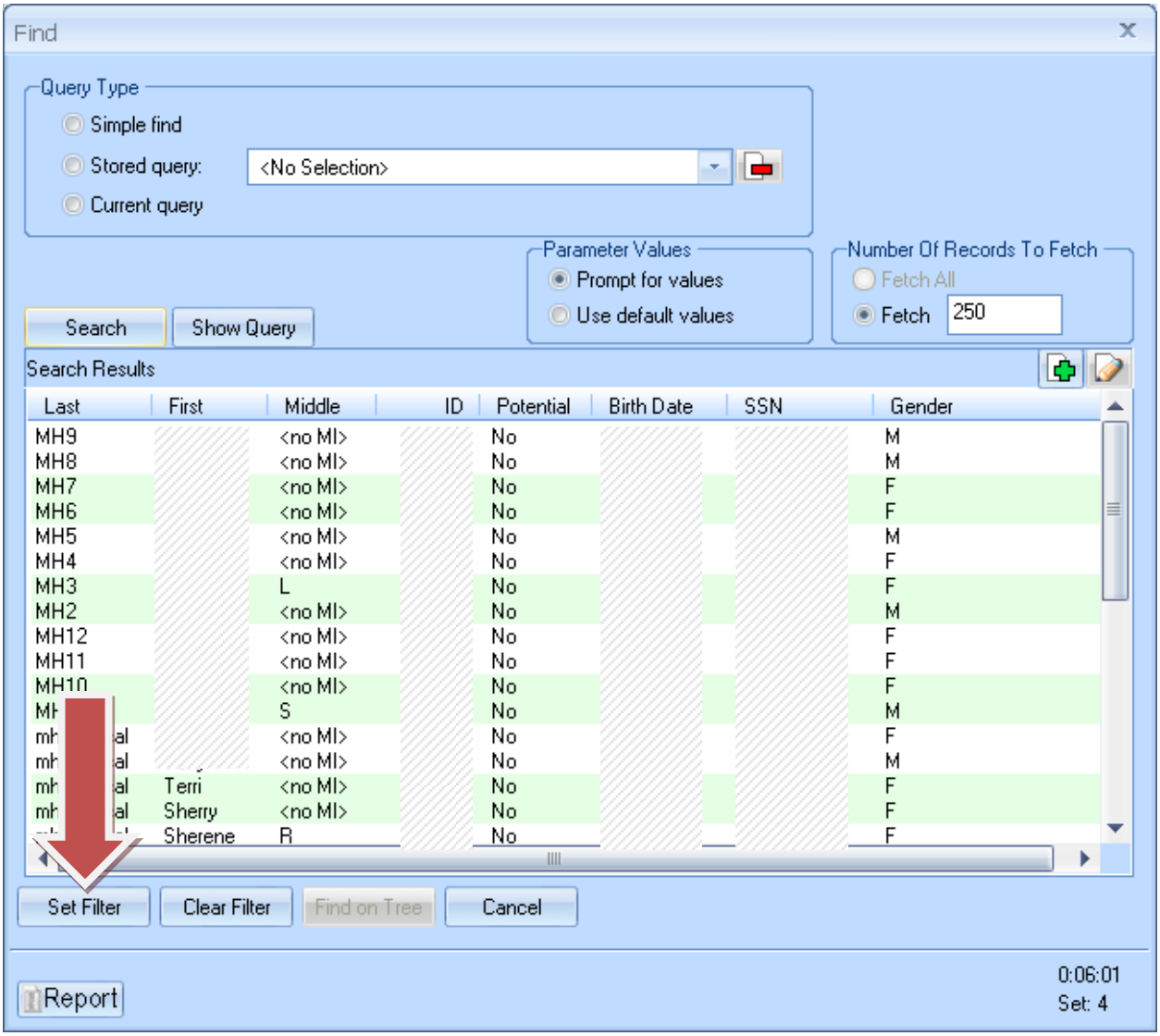
Click the **Search** button.



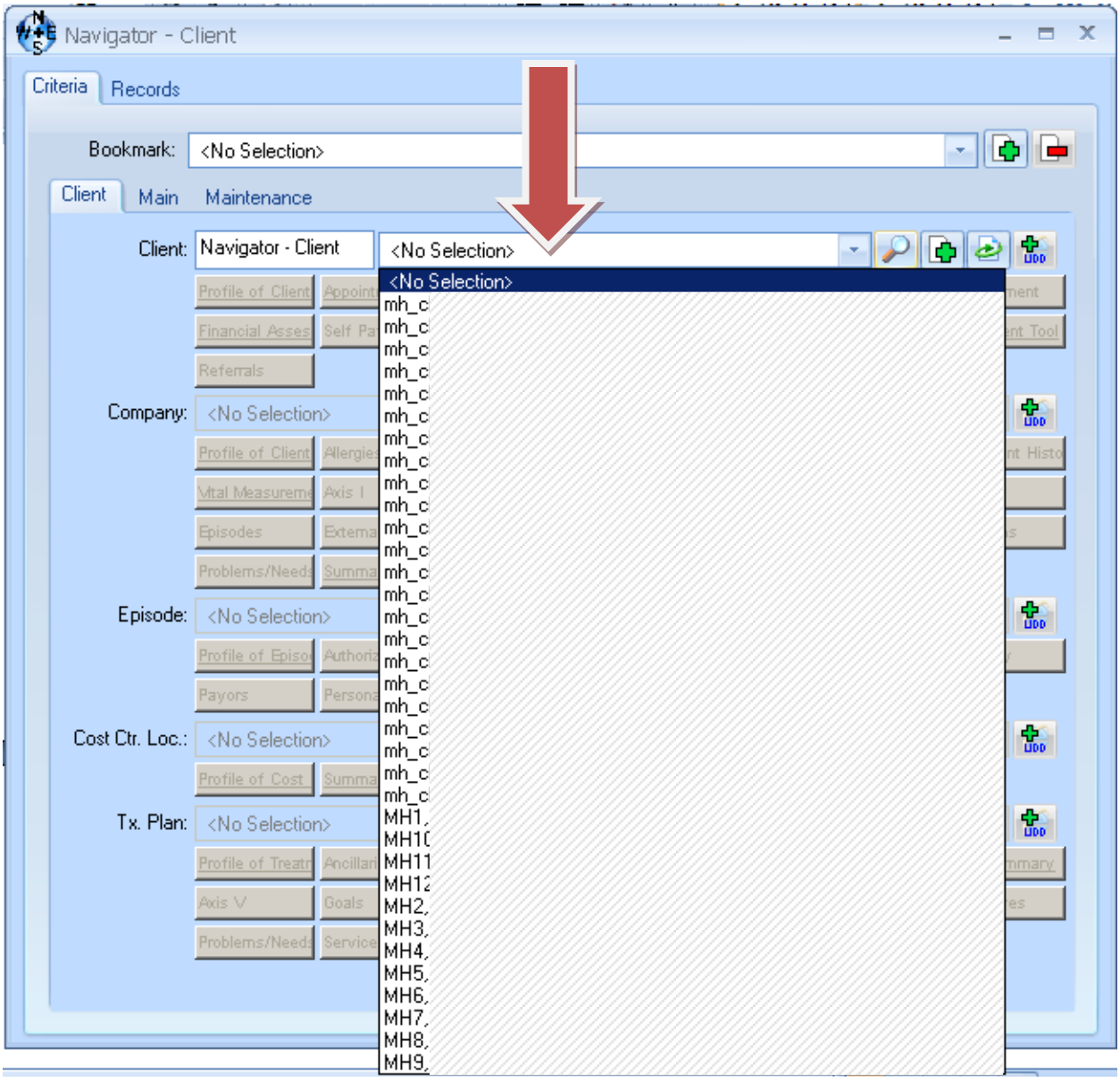
Enter your Unicare Provider Code and click **OK**.



Your caseload will appear. Click **Set Filter**. There is no need to highlight any names.



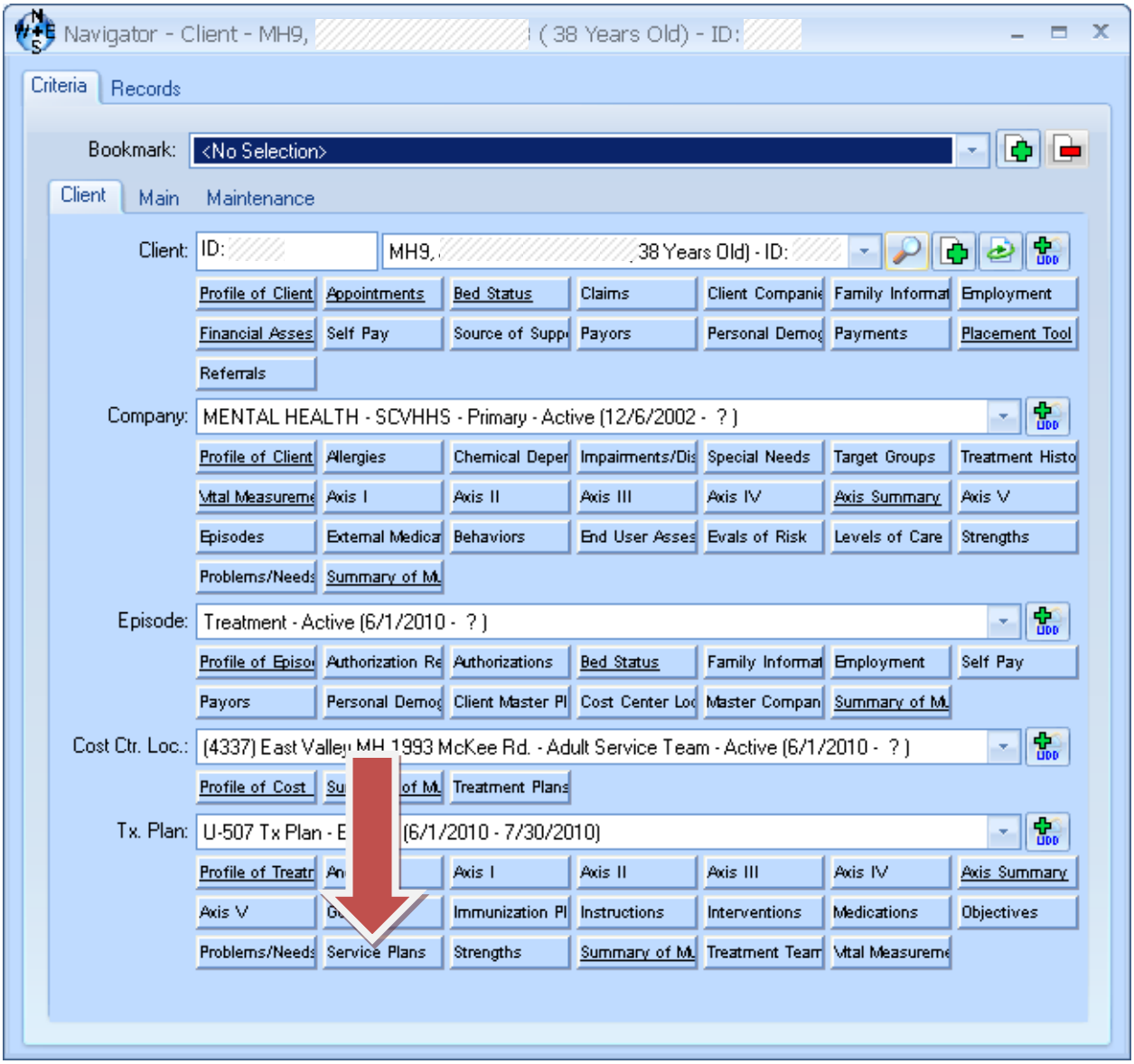
The Navigator screen will appear. Click in the dropdown field next to the Client: Navigator – Client field. All of your caseload will appear and they will stay there until you perform another Find Client search using the 901 Stored Query method.



Choose a client. Make sure that all of the five fields are filled in correctly, i.e., Client, Company, Episode, Cost Ctr. Loc. and Tx Plan. Only choose an Active field. Never choose an Expired field.

Note: You need to periodically check these five fields to make sure that they are Active and not Expired. You will not be able to enter any services if any of these fields are Expired.

Click the **Service Plans** button at the bottom.

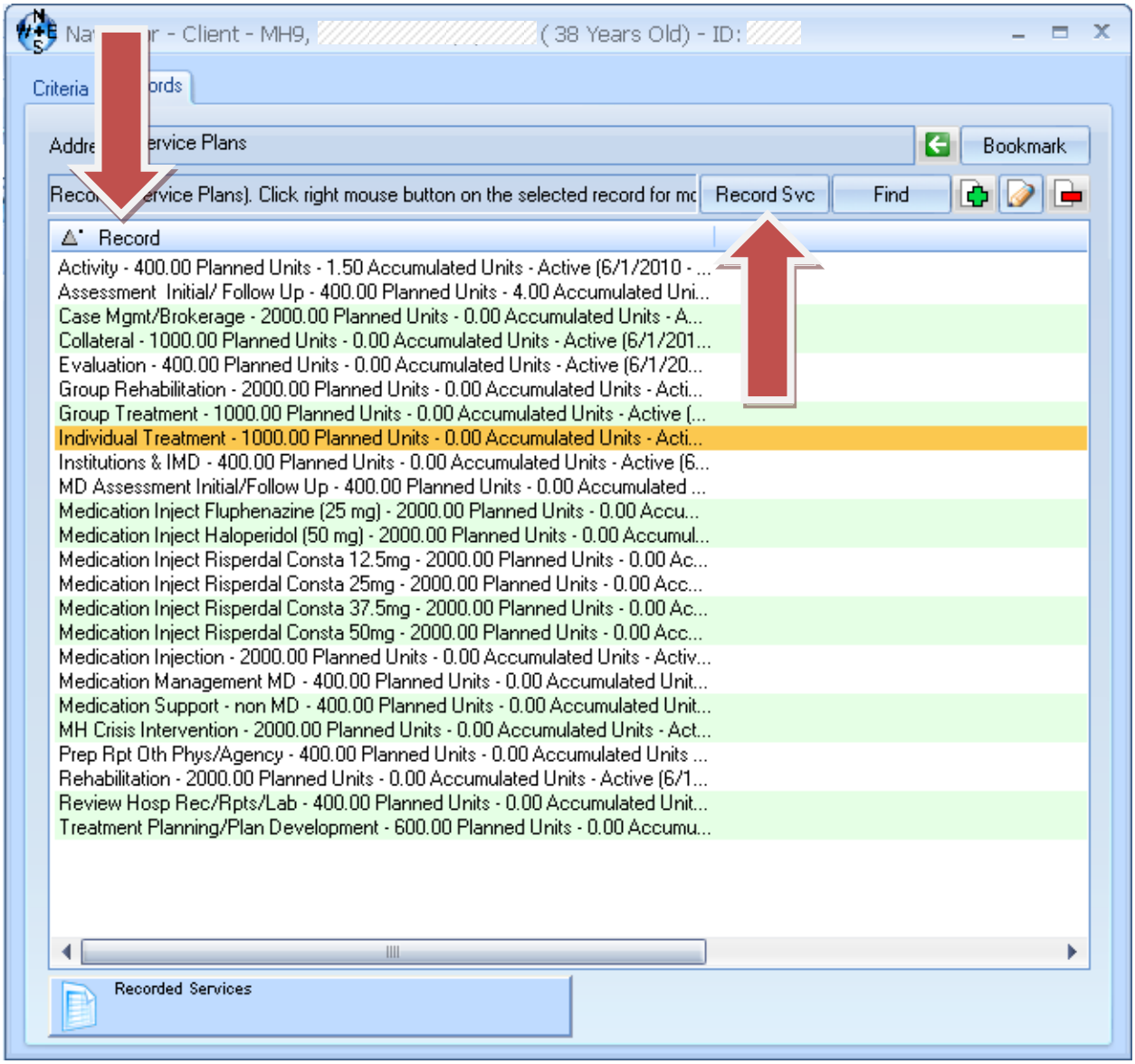


All of the client's planned services appear.

Note: If they are not in alphabetical order, you can click on Record and this will put them in alpha order.

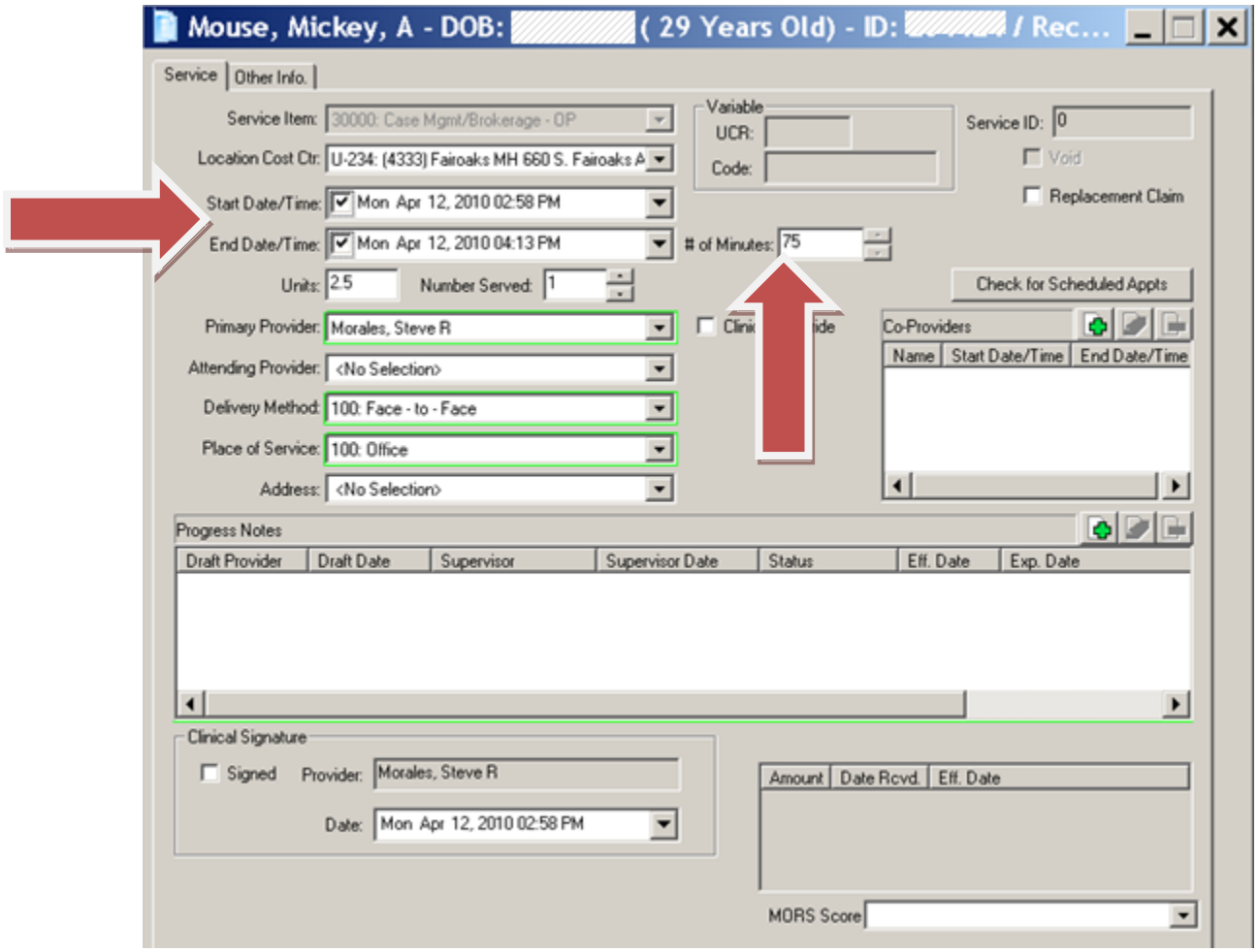
Highlight the service you want to record with one click and then click on **Record Svc**.

Note: Use Activity service to record Non-reimbursable services.


Criteria
Service Plans
Bookmark
Record Svc
Find
Record
Activity - 400.00 Planned Units - 1.50 Accumulated Units - Active (6/1/2010 - ...
Assessment Initial/ Follow Up - 400.00 Planned Units - 4.00 Accumulated Uni...
Case Mgmt/Brokerage - 2000.00 Planned Units - 0.00 Accumulated Units - A...
Collateral - 1000.00 Planned Units - 0.00 Accumulated Units - Active (6/1/201...
Evaluation - 400.00 Planned Units - 0.00 Accumulated Units - Active (6/1/20...
Group Rehabilitation - 2000.00 Planned Units - 0.00 Accumulated Units - Acti...
Group Treatment - 1000.00 Planned Units - 0.00 Accumulated Units - Active (...
Individual Treatment - 1000.00 Planned Units - 0.00 Accumulated Units - Acti...
Institutions & IMD - 400.00 Planned Units - 0.00 Accumulated Units - Active (6...
MD Assessment Initial/Follow Up - 400.00 Planned Units - 0.00 Accumulated ...
Medication Inject Fluphenazine (25 mg) - 2000.00 Planned Units - 0.00 Accu...
Medication Inject Haloperidol (50 mg) - 2000.00 Planned Units - 0.00 Accumul...
Medication Inject Risperdal Consta 12.5mg - 2000.00 Planned Units - 0.00 Ac...
Medication Inject Risperdal Consta 25mg - 2000.00 Planned Units - 0.00 Acc...
Medication Inject Risperdal Consta 37.5mg - 2000.00 Planned Units - 0.00 Ac...
Medication Inject Risperdal Consta 50mg - 2000.00 Planned Units - 0.00 Acc...
Medication Injection - 2000.00 Planned Units - 0.00 Accumulated Units - Activ...
Medication Management MD - 400.00 Planned Units - 0.00 Accumulated Unit...
Medication Support - non MD - 400.00 Planned Units - 0.00 Accumulated Unit...
MH Crisis Intervention - 2000.00 Planned Units - 0.00 Accumulated Units - Act...
Prep Rpt Oth Phys/Agency - 400.00 Planned Units - 0.00 Accumulated Units ...
Rehabilitation - 2000.00 Planned Units - 0.00 Accumulated Units - Active (6/1...
Review Hosp Rec/Rpts/Lab - 400.00 Planned Units - 0.00 Accumulated Unit...
Treatment Planning/Plan Development - 600.00 Planned Units - 0.00 Accumu...
Recorded Services

RECORDING A SERVICE

1. Check the **Start Date/Time** box.
   Note: If you are entering a service that is not the default date on the screen, then you will need to change this date. Highlight the date or time then use the arrow keys or number keys on your keyboard. You can also click on the dropdown arrow to the right of the field and a calendar will appear.
2. Check the **End Date/Time** box. The End Date will automatically change to match the Start Date and will fill in your name in the Primary Provider field.
3. Enter the total staff time in minutes in the **# of Minutes** field. This includes the actual service time, documentation time and travel time, if any.



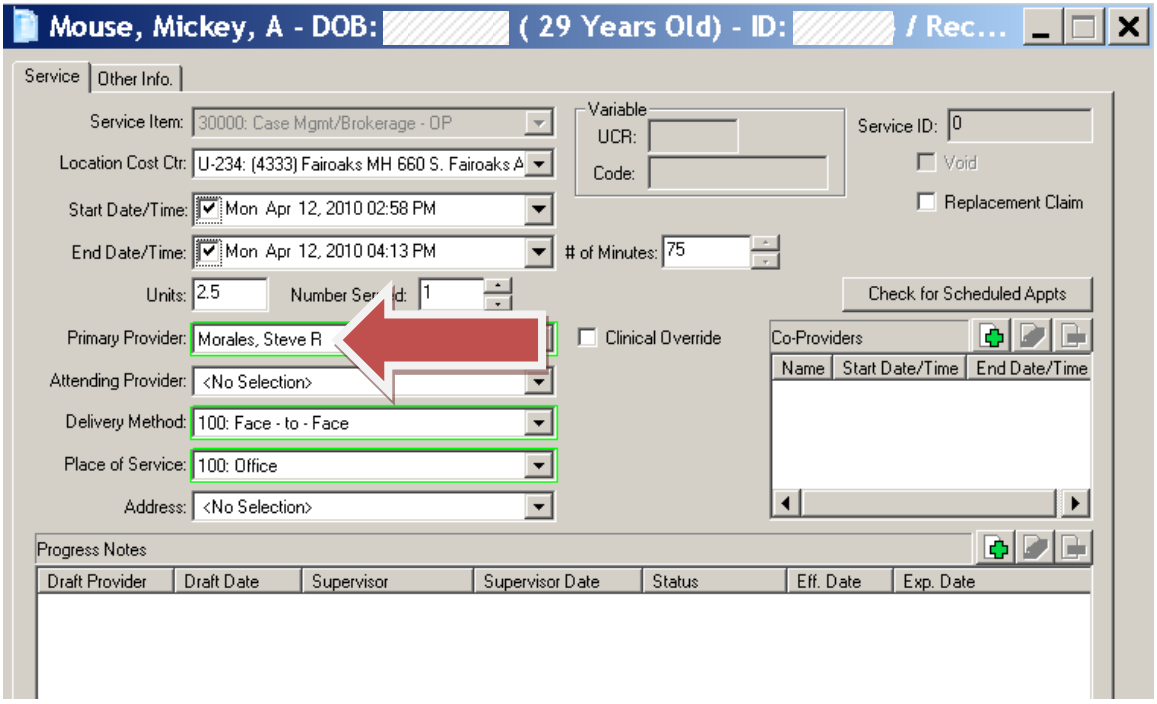
Primary Provider - Your name should automatically be filled in after you click the End Date/Time box. If this does not happen, click the dropdown menu and choose your name. If your name is not listed, talk with your clerical staff.

Note: Do not enter or change the Number Served or the Attending Provider fields.

Note: Some fields on this screen are either encased in a green halo or are underlined in green.

A. Fields that are encased in a green halo are required fields, in other words, you must fill them in.

B. Fields that are underlined in green are desired fields – it is optional to fill it in.

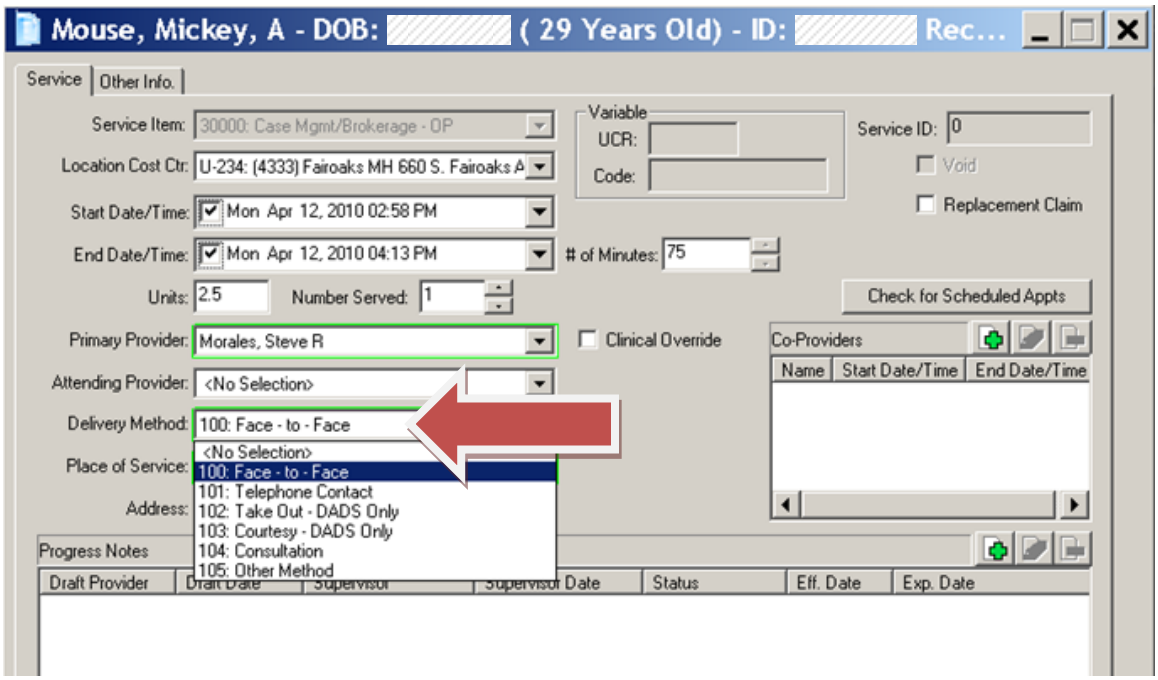


Delivery Method - Unicare defaults to Face-to-Face. If you need to change it, click the dropdown menu and make your choice.

As you can see in the screen shot below, there are six choices. Mental health providers are only allowed to use four of these – Face-to-Face, Telephone Contact, Consultation and Other Method. Take Out and Courtesy are used only by DADS.

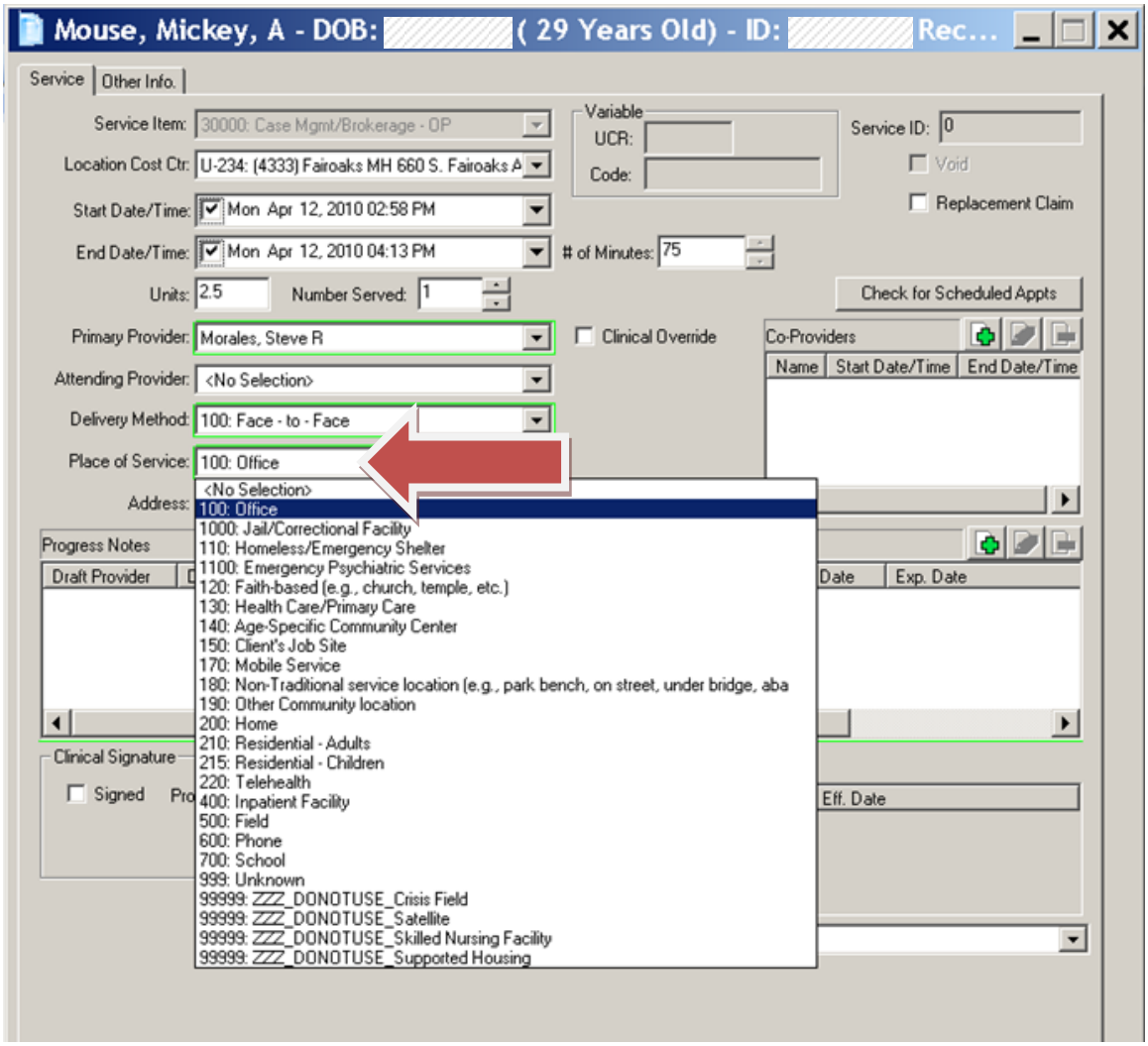
Here are the definitions on the **Delivery Method** choices:

1. Face-to-Face is used when you provide a face-to-face service to clients and/or significant support persons.
2. Telephone Contact is used for telephone contacts with clients and/or significant support persons.
3. Consultation is used for all contacts with other professionals.
4. Other Method is used for services and/or activities like writing a Treatment Plan without the client or writing a letter.



Place of Service is the next field to be filled in. Unicare defaults to Office. If you need to change it, click on the dropdown menu and make your choice.

See Appendix B for the **Place of Service** dictionary.

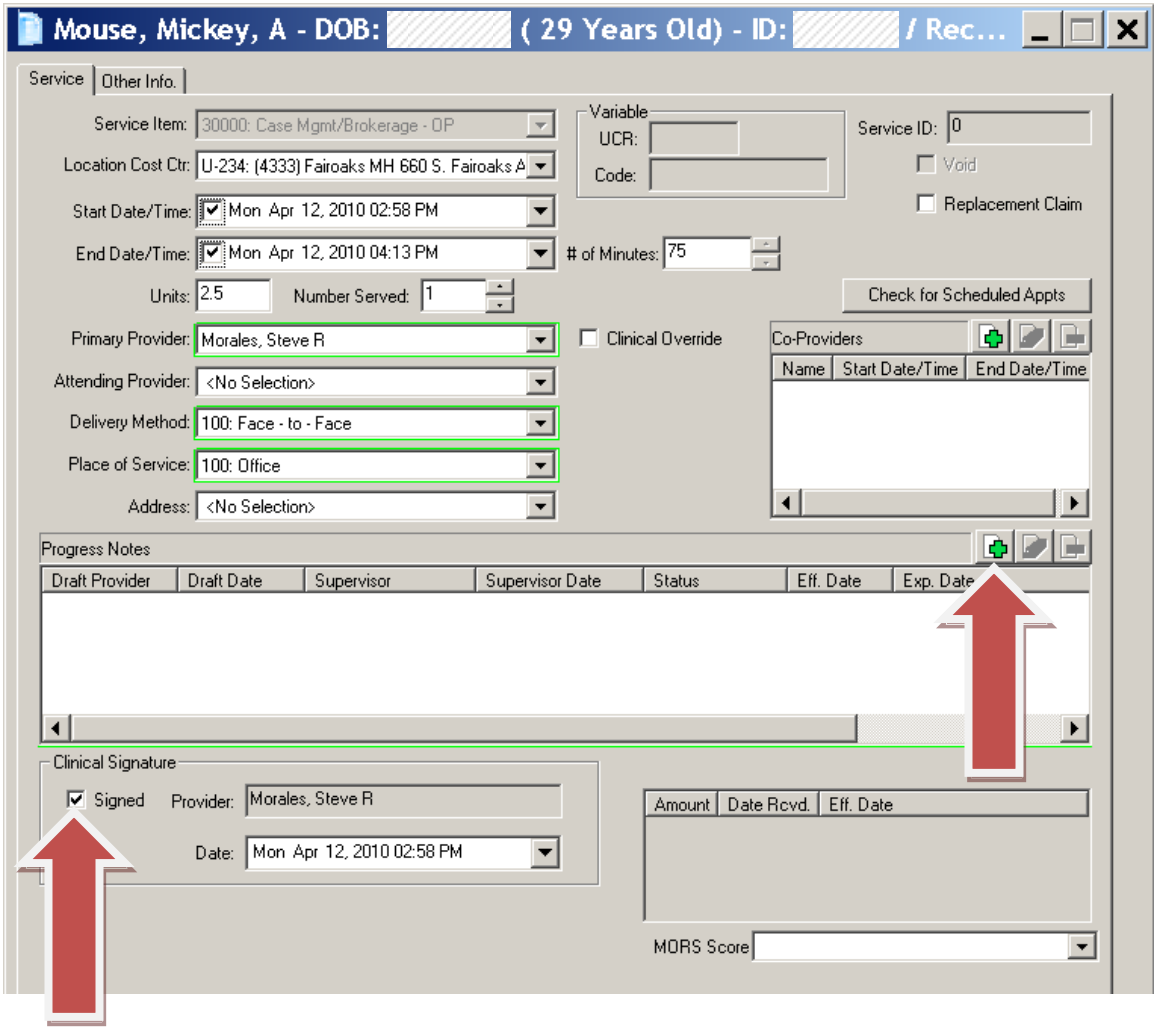


1. Check the **Clinical Signature** box in the lower left-hand corner. This is mandatory. Checking this box locks down the Recorded Service screen so that it cannot be changed after you click the Save button.

Note 1: Clicking this box does not take the place of wet signing your name and credentials on your progress note. You still must wet sign every progress note if you are printing your progress notes.

2. Click the **Add Progress Note** icon, the green plus sign.

Note 2: Do not use the Co-Providers section on this screen, even if you are providing group treatment with more than one provider. This is used only by DADS.

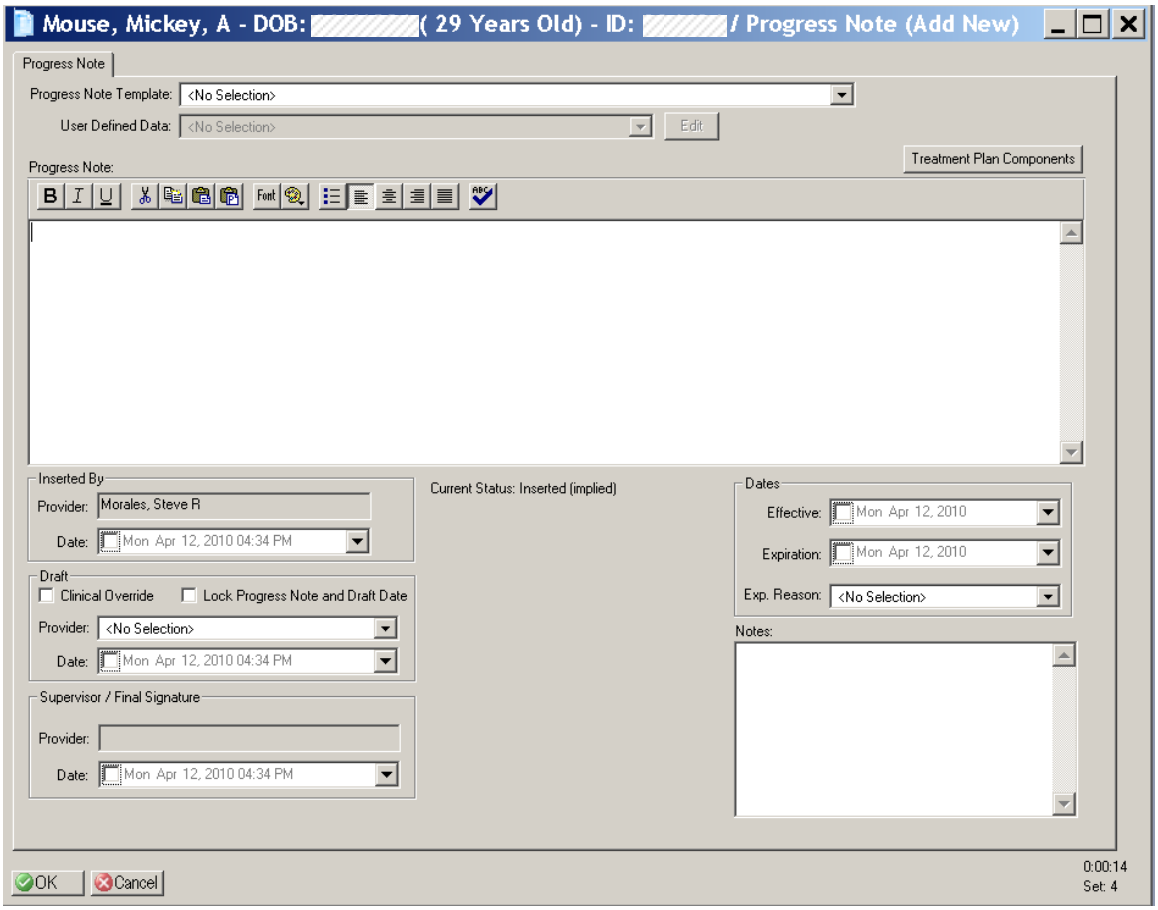


RECORDING A PROGRESS NOTE

Enter your progress note in the large white box by clicking in the box and then start typing.

There are editing tools for the progress notes. Use these as you would any other Word processing document.

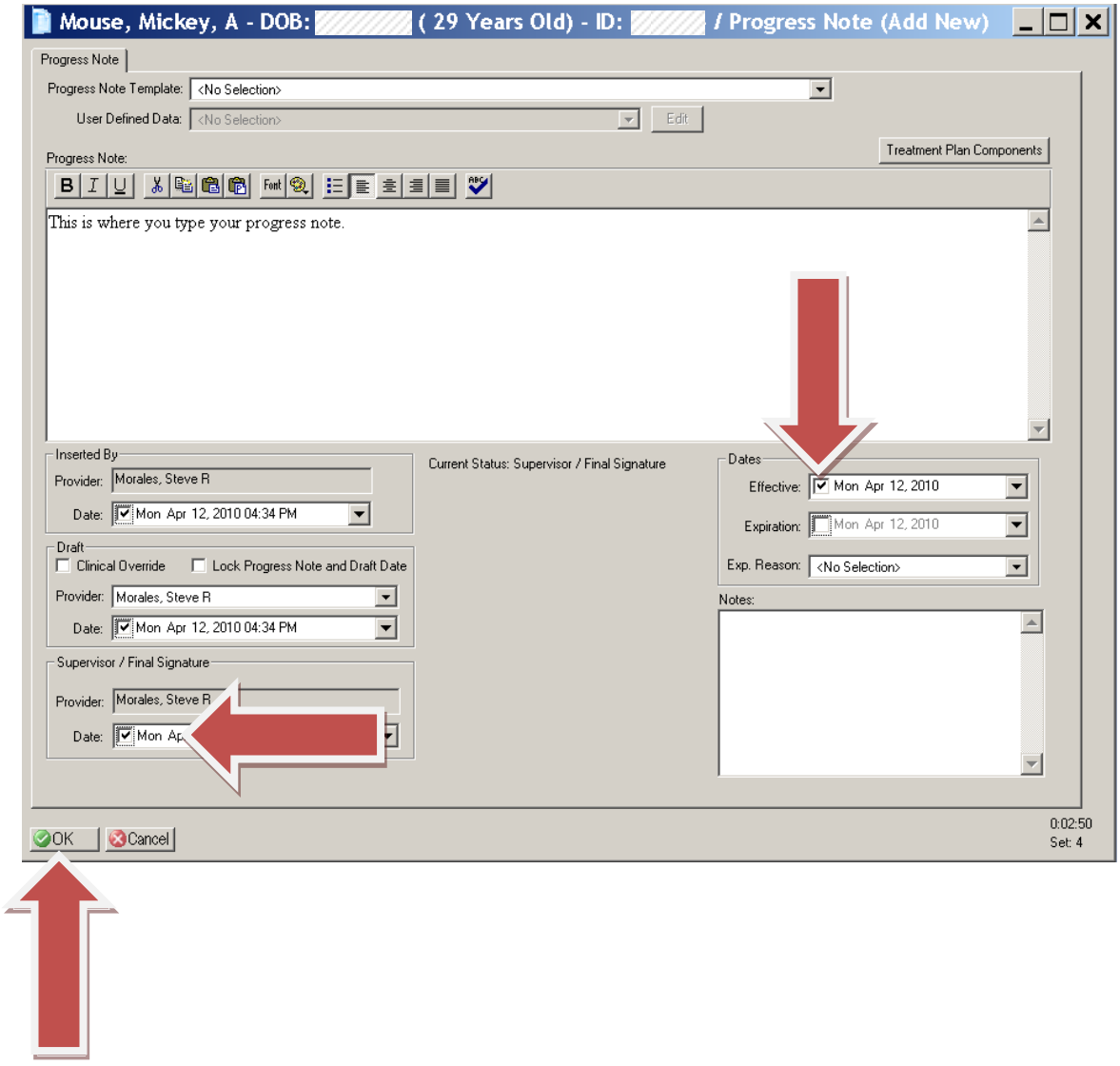
There is a Spell Checker for the progress notes. A red wavy line will indicate that Unicare does not recognize a word. Place your cursor over the word and then right-click for options.



After completing your progress note:

1. Click the **Effective Date** box. No need to change the date. Never expire a progress note.
2. Click the **Supervisor/Final Signature Date** box.
3. Click **OK**.

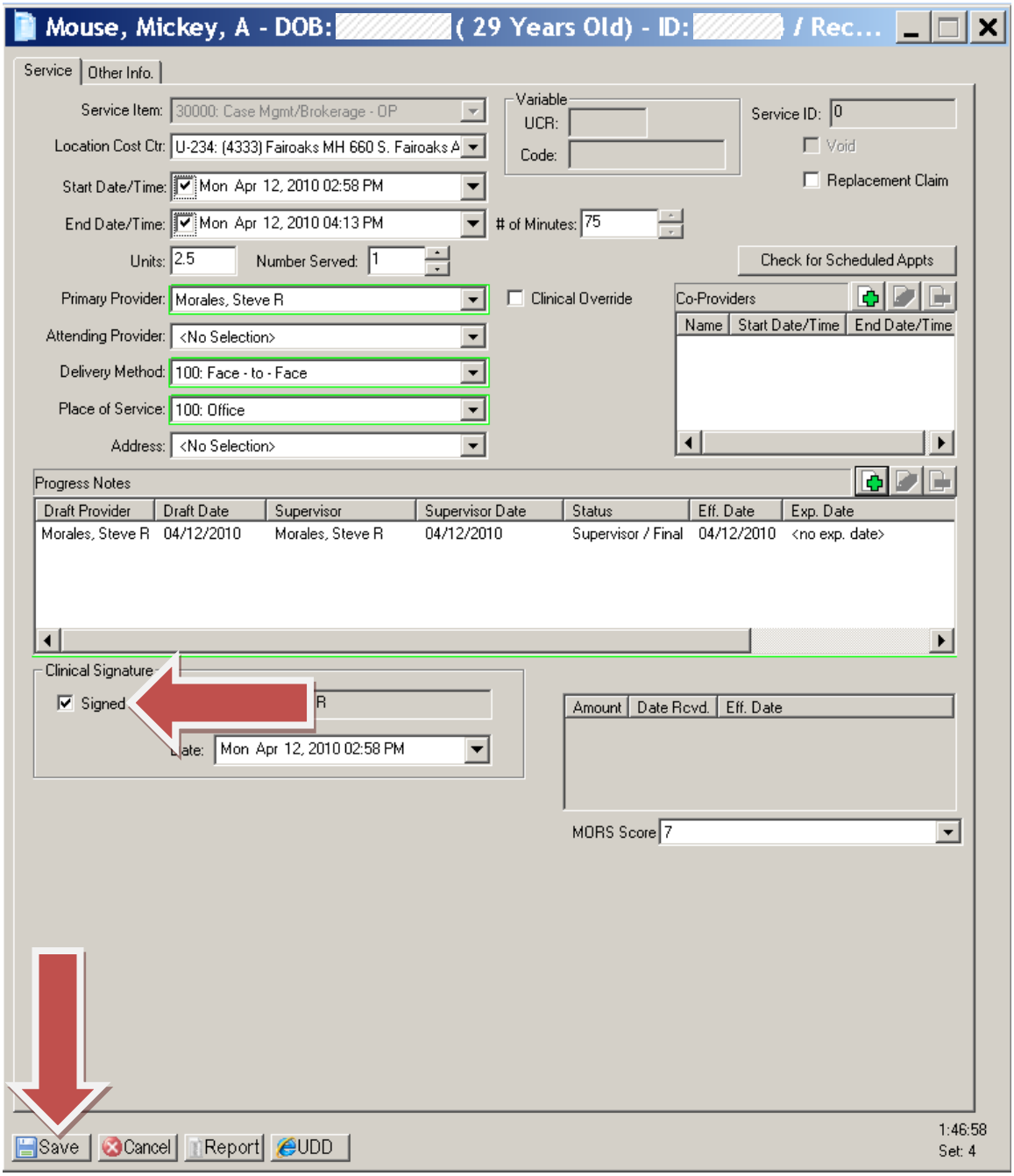
Note: After you click OK, you cannot go back and edit your progress note. If you find that you made a mistake, you may need to void your service. Voids are covered later in the manual.



You are returned to the Recorded Service screen. A Progress Note entry is now displayed.

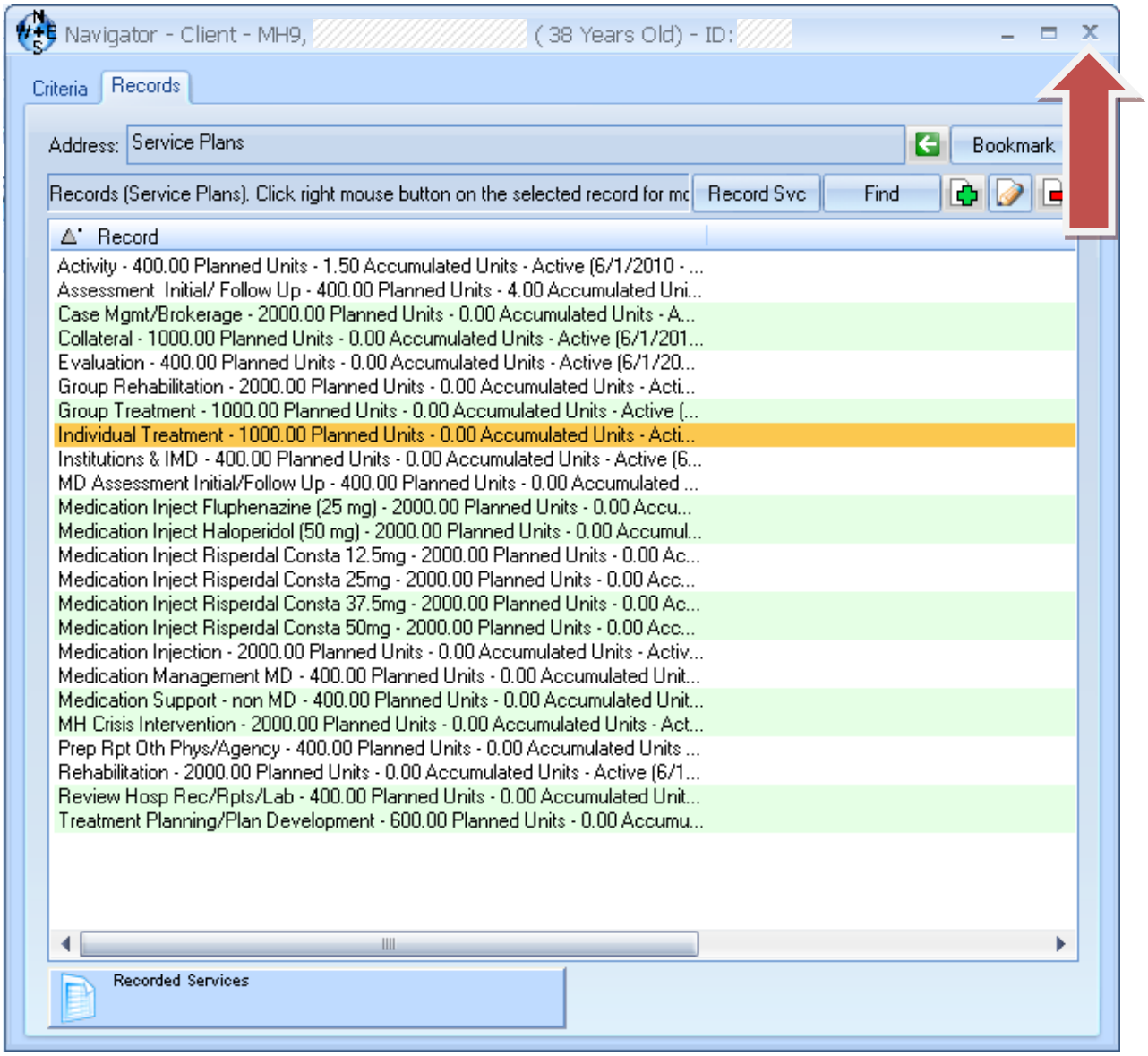
Check the **Clinical Signature Signed** box if you have not done so. This is mandatory.

Click **Save** and you will be returned to the Navigator screen.



If you need to record another service on this same client for the same day or another day, highlight that service, click Record Svc. and proceed as usual.

When you are finished recording services, you can close the Navigator window by clicking on the X in the top, right-hand corner.


Navigator - Client - MH9, (38 Years Old) - ID:
Criteria
Records
Address: Service Plans
Bookmark
Records (Service Plans). Click right mouse button on the selected record for mc
Record Svc
Find
Record
Activity - 400.00 Planned Units - 1.50 Accumulated Units - Active (6/1/2010 - ...
Assessment Initial/ Follow Up - 400.00 Planned Units - 4.00 Accumulated Uni...
Case Mgmt/Brokerage - 2000.00 Planned Units - 0.00 Accumulated Units - A...
Collateral - 1000.00 Planned Units - 0.00 Accumulated Units - Active (6/1/201...
Evaluation - 400.00 Planned Units - 0.00 Accumulated Units - Active (6/1/20...
Group Rehabilitation - 2000.00 Planned Units - 0.00 Accumulated Units - Acti...
Group Treatment - 1000.00 Planned Units - 0.00 Accumulated Units - Active (...
Individual Treatment - 1000.00 Planned Units - 0.00 Accumulated Units - Acti...
Institutions & IMD - 400.00 Planned Units - 0.00 Accumulated Units - Active (6...
MD Assessment Initial/Follow Up - 400.00 Planned Units - 0.00 Accumulated ...
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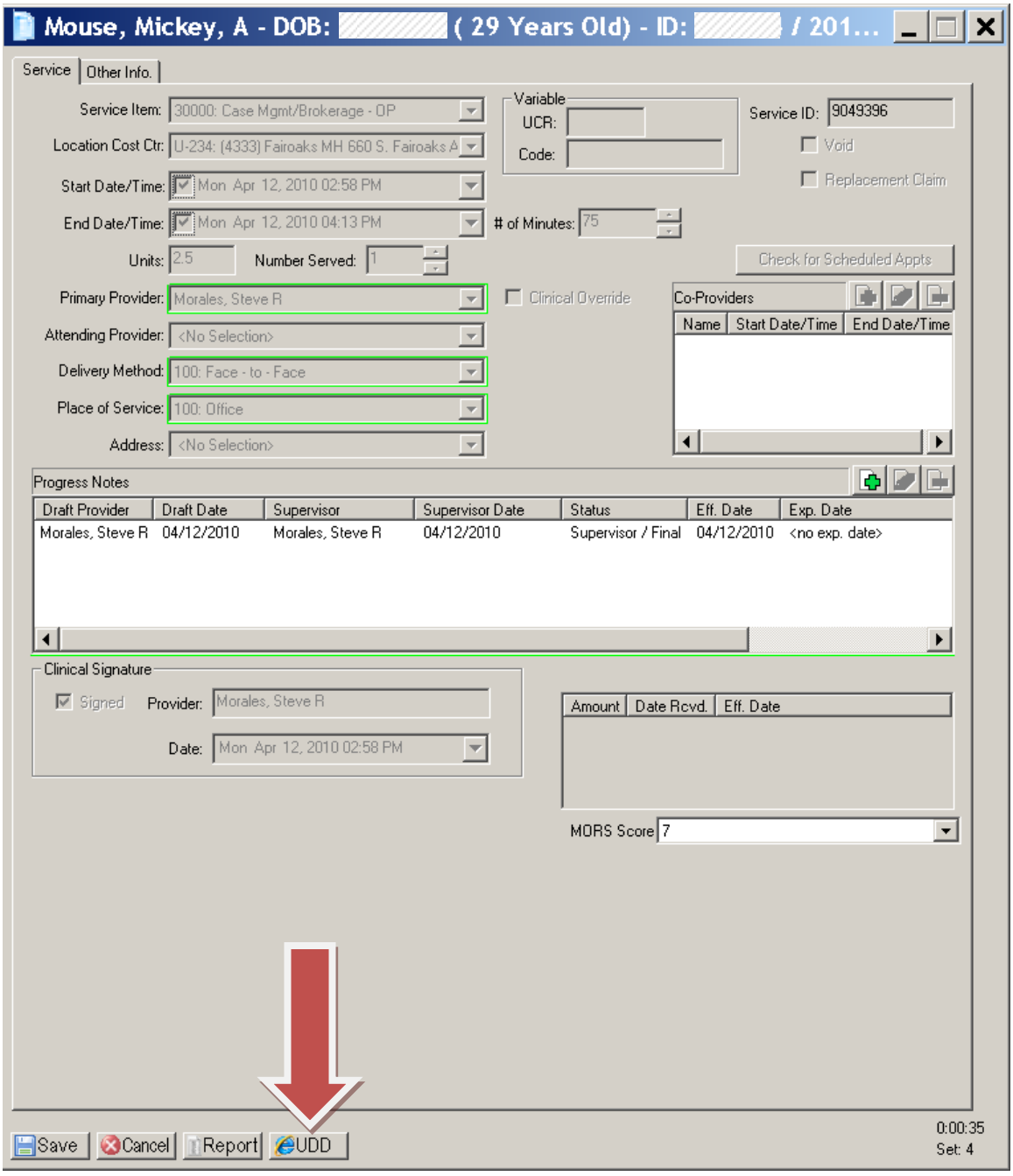
Medication Inject Risperdal Consta 12.5mg - 2000.00 Planned Units - 0.00 Ac...
Medication Inject Risperdal Consta 25mg - 2000.00 Planned Units - 0.00 Acc...
Medication Inject Risperdal Consta 37.5mg - 2000.00 Planned Units - 0.00 Ac...
Medication Inject Risperdal Consta 50mg - 2000.00 Planned Units - 0.00 Acc...
Medication Injection - 2000.00 Planned Units - 0.00 Accumulated Units - Activ...
Medication Management MD - 400.00 Planned Units - 0.00 Accumulated Unit...
Medication Support - non MD - 400.00 Planned Units - 0.00 Accumulated Unit...
MH Crisis Intervention - 2000.00 Planned Units - 0.00 Accumulated Units - Act...
Prep Rpt Oth Phys/Agency - 400.00 Planned Units - 0.00 Accumulated Units ...
Rehabilitation - 2000.00 Planned Units - 0.00 Accumulated Units - Active (6/1...
Review Hosp Rec/Rpts/Lab - 400.00 Planned Units - 0.00 Accumulated Unit...
Treatment Planning/Plan Development - 600.00 Planned Units - 0.00 Accumu...
Recorded Services

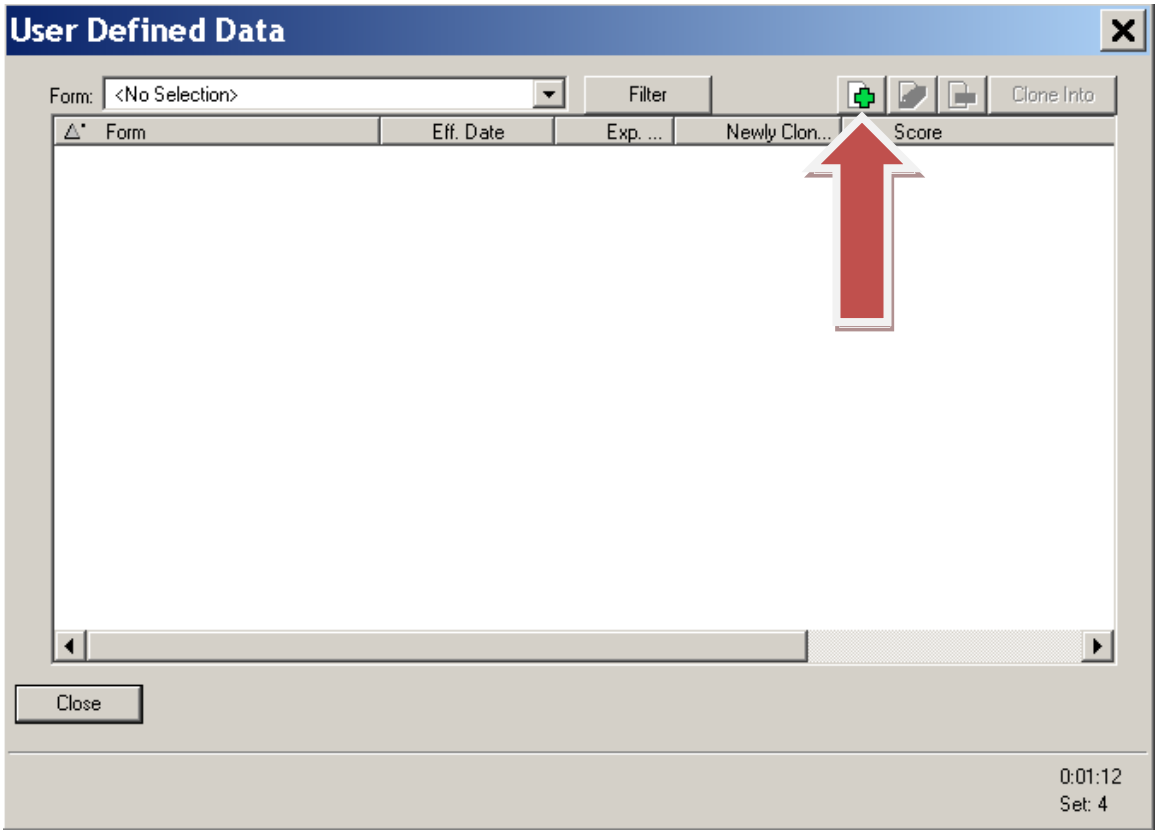
RECORDING AN EVIDENCE-BASED PRACTICE/SERVICE STRATEGY (EBP/SS)

An Evidence-Based Practice and/or Service Strategy (EBP/SS) must be recorded for all services except Activity, Institutions and IMD and FSP Linkage. See Appendix C for further discussion on EBP/SS and dictionaries.

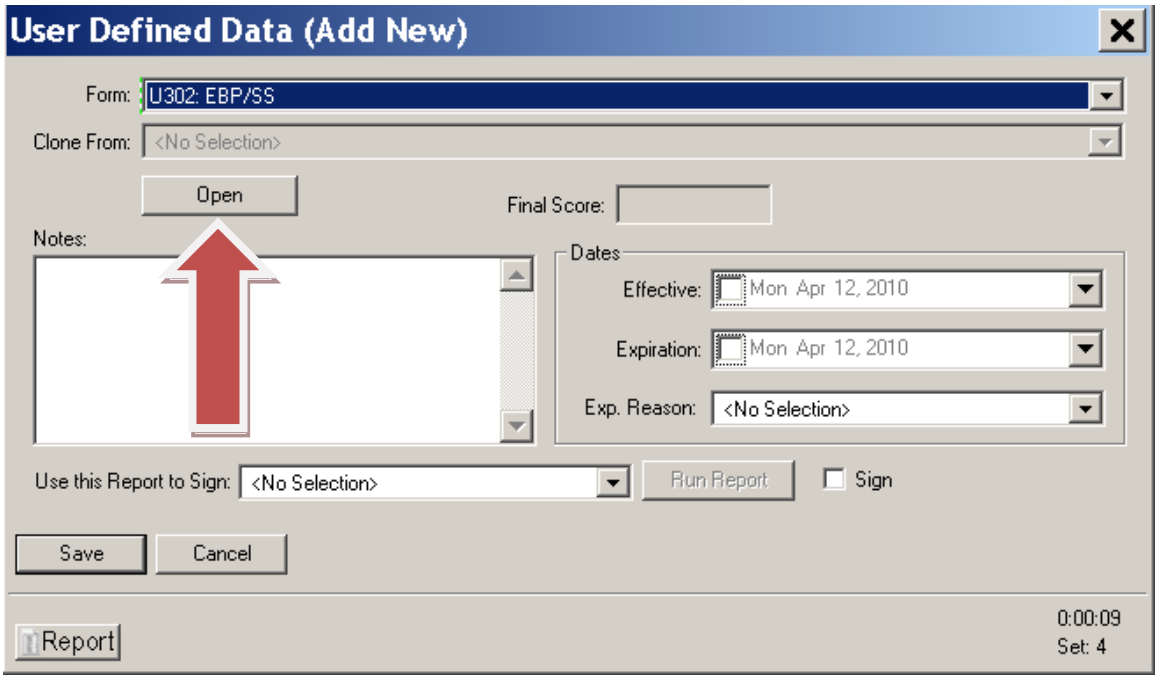
Click the User Defined Data (**UDD**) button on the Recorded Service screen.



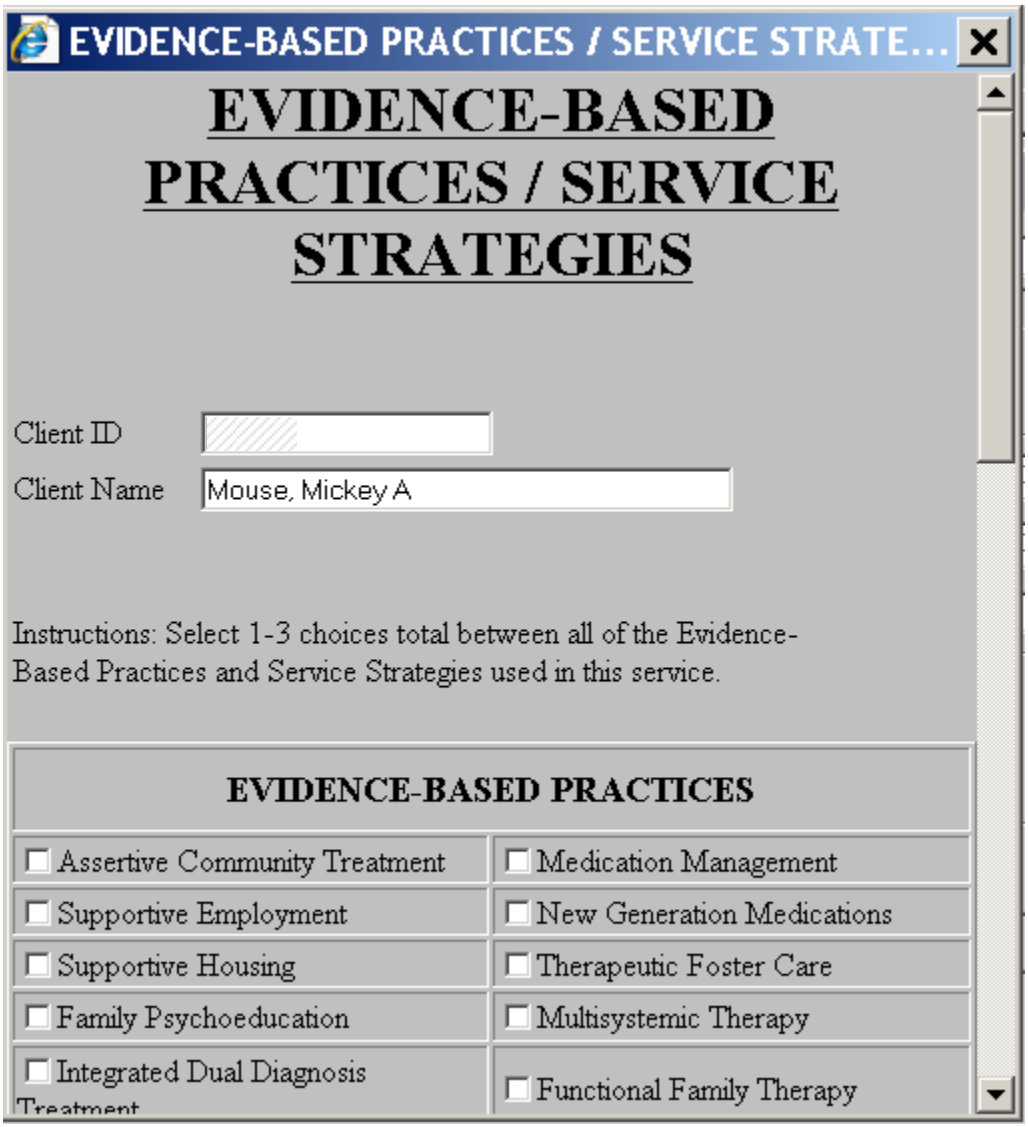
Click the **Add New** icon.



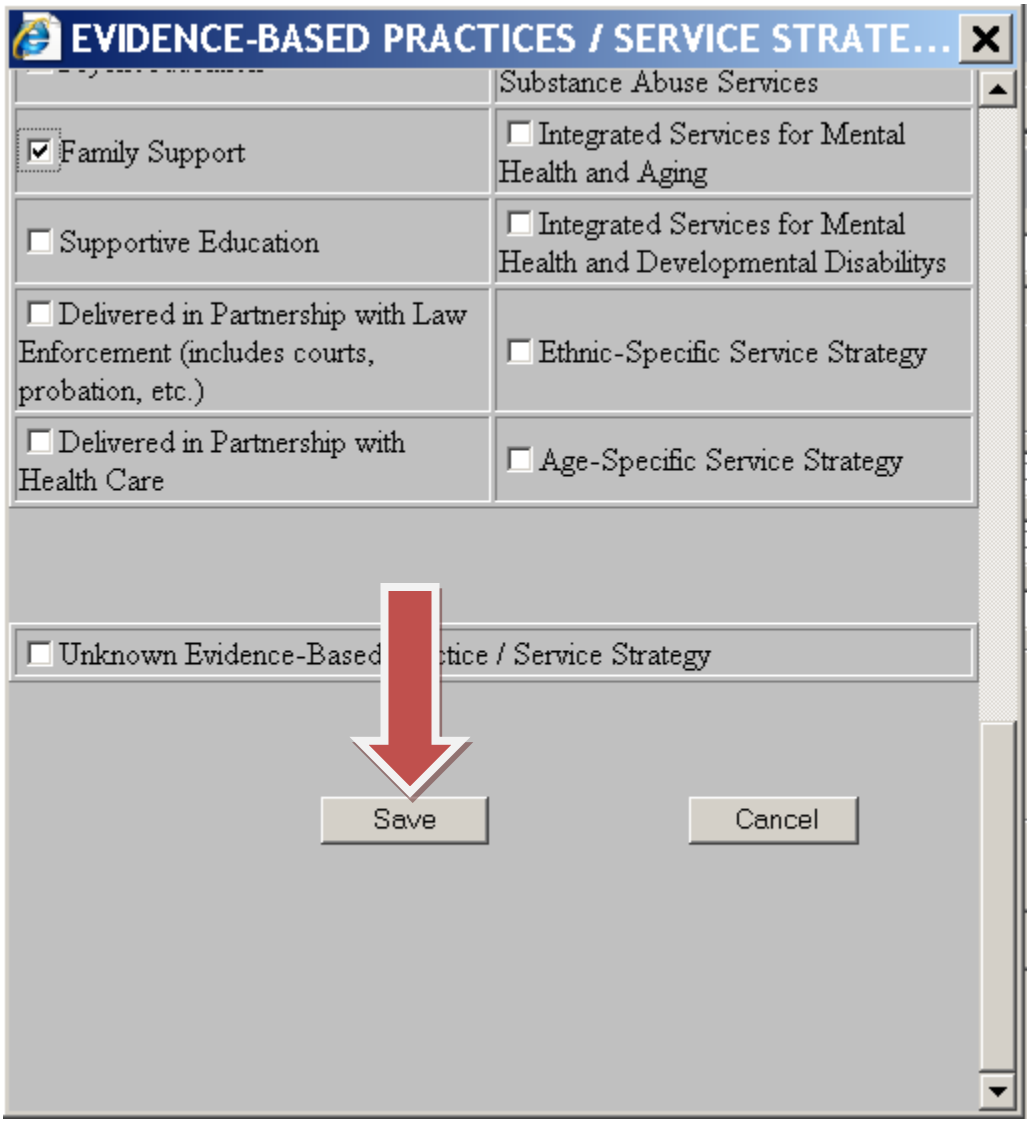
Click **Open**. The Form has already been defaulted to EBP/SS. There is no need for you to click on the dropdown arrow.



Scroll down to see the entire form. Choose from one to three choices between the Evidence-Based Practices and/or the Service Strategies, or choose Unknown.

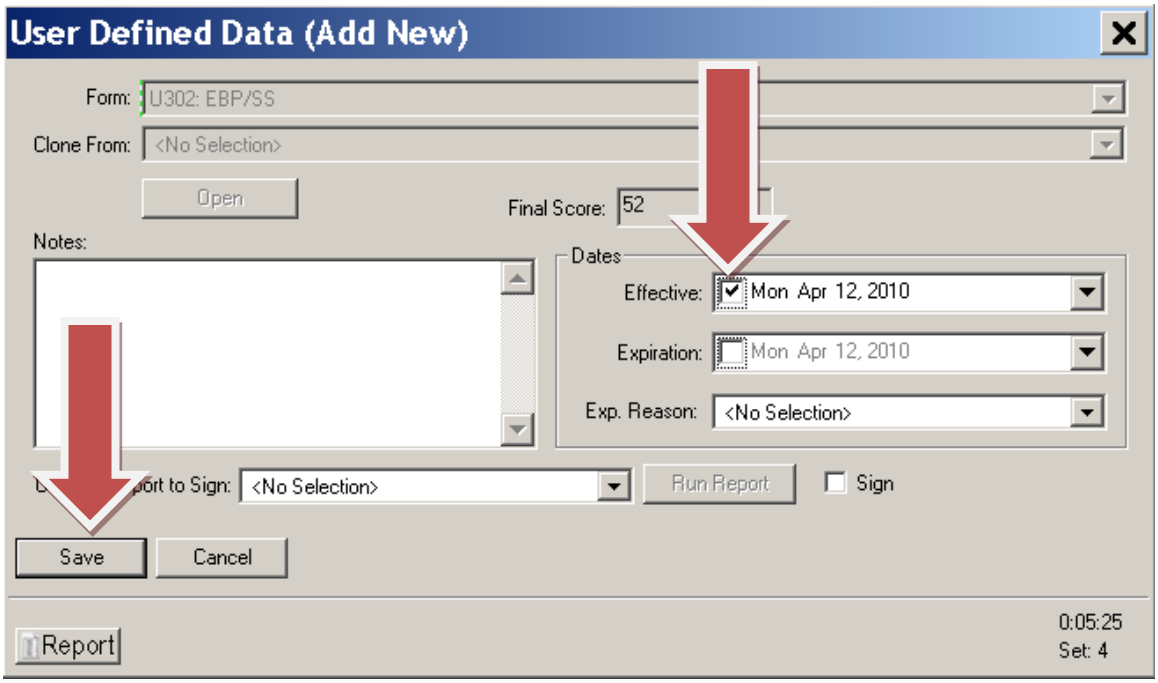


After you make your selection, click **Save**.

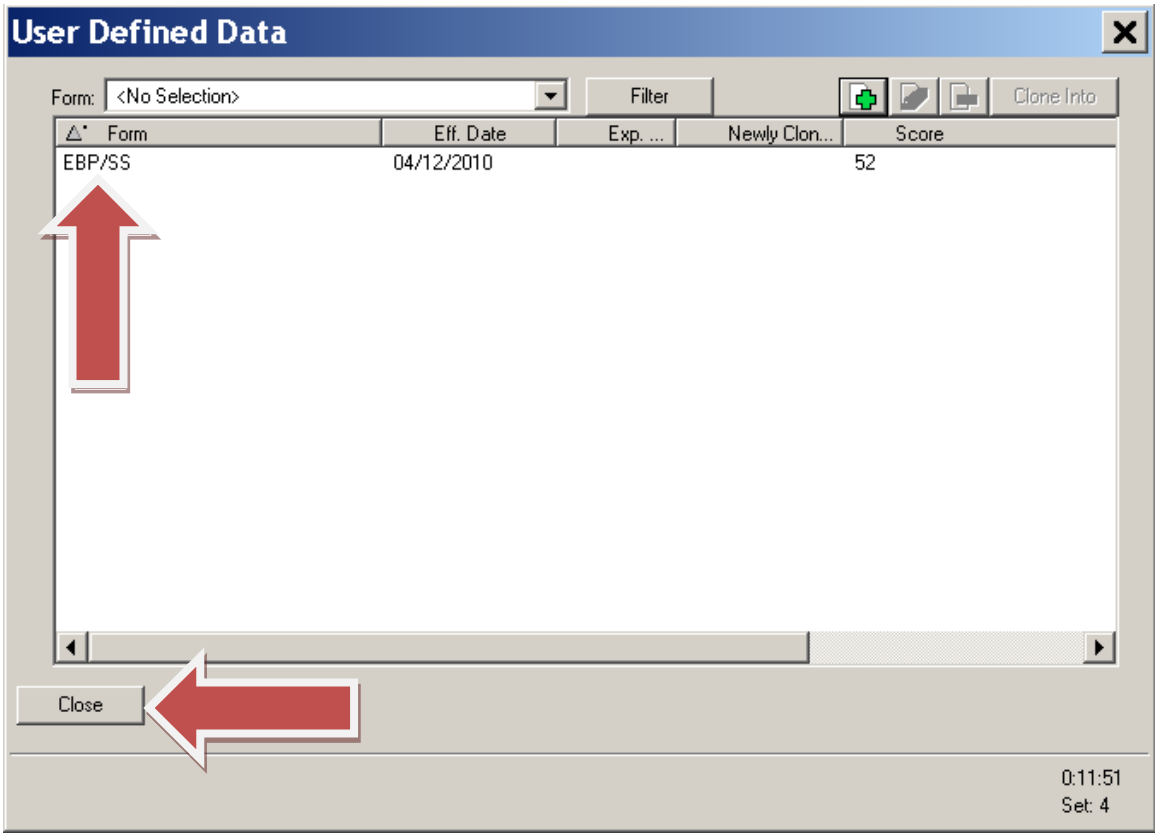

EVIDENCE-BASED PRACTICES / SERVICE STRATE...
Substance Abuse Services
Family Support
Integrated Services for Mental Health and Aging
Supportive Education
Integrated Services for Mental Health and Developmental Disabilitys
Delivered in Partnership with Law Enforcement (includes courts, probation, etc.)
Ethnic-Specific Service Strategy
Delivered in Partnership with Health Care
Age-Specific Service Strategy
Unknown Evidence-Based
tice / Service Strategy
Save
Cancel

Notice that the Final Score field is now filled in. This indicates which choice you made.

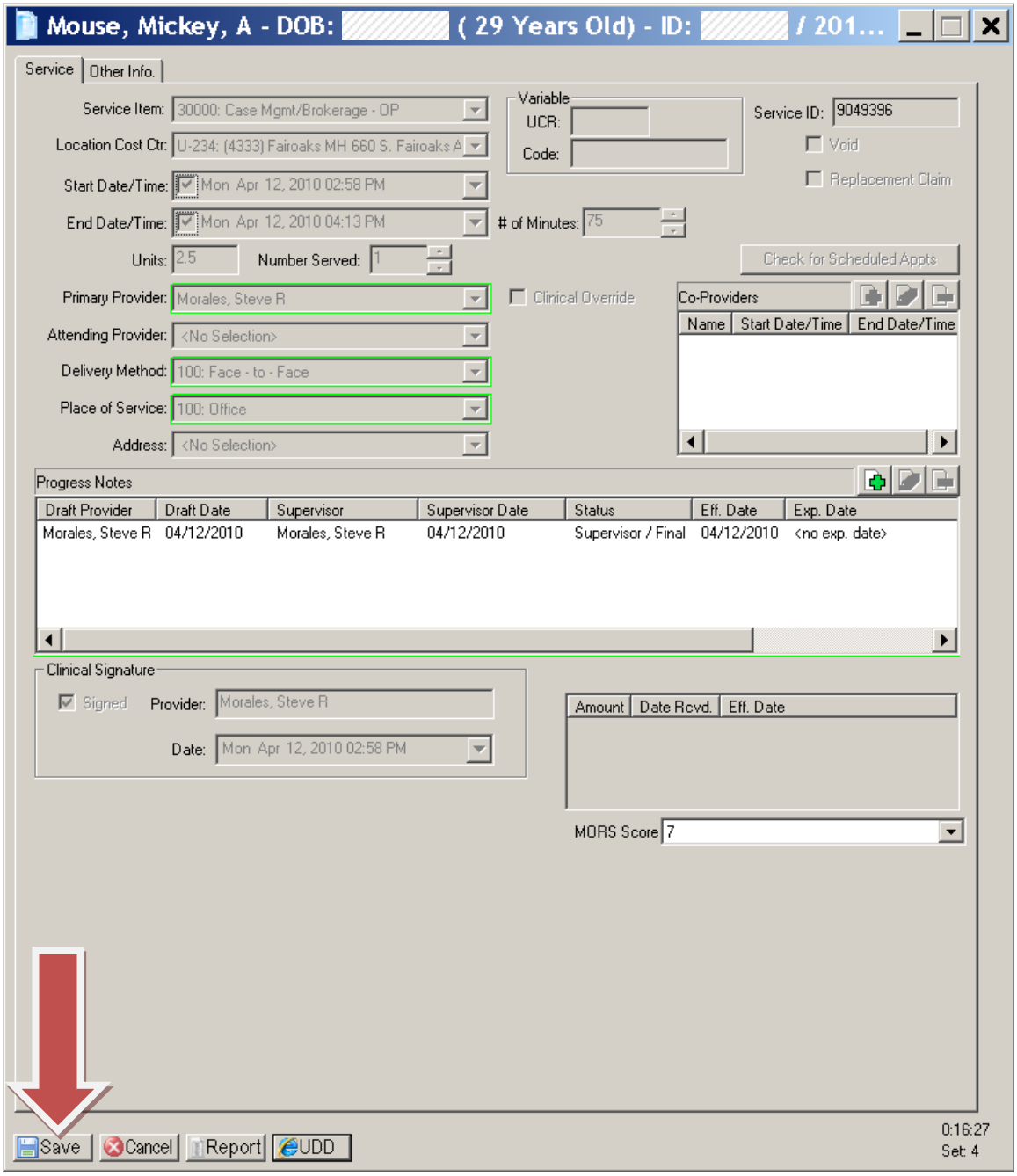
1. Click the **Effective Date** box.
2. Click **Save**.



Wait until your EBP/SS shows up in the field and then click **Close**.



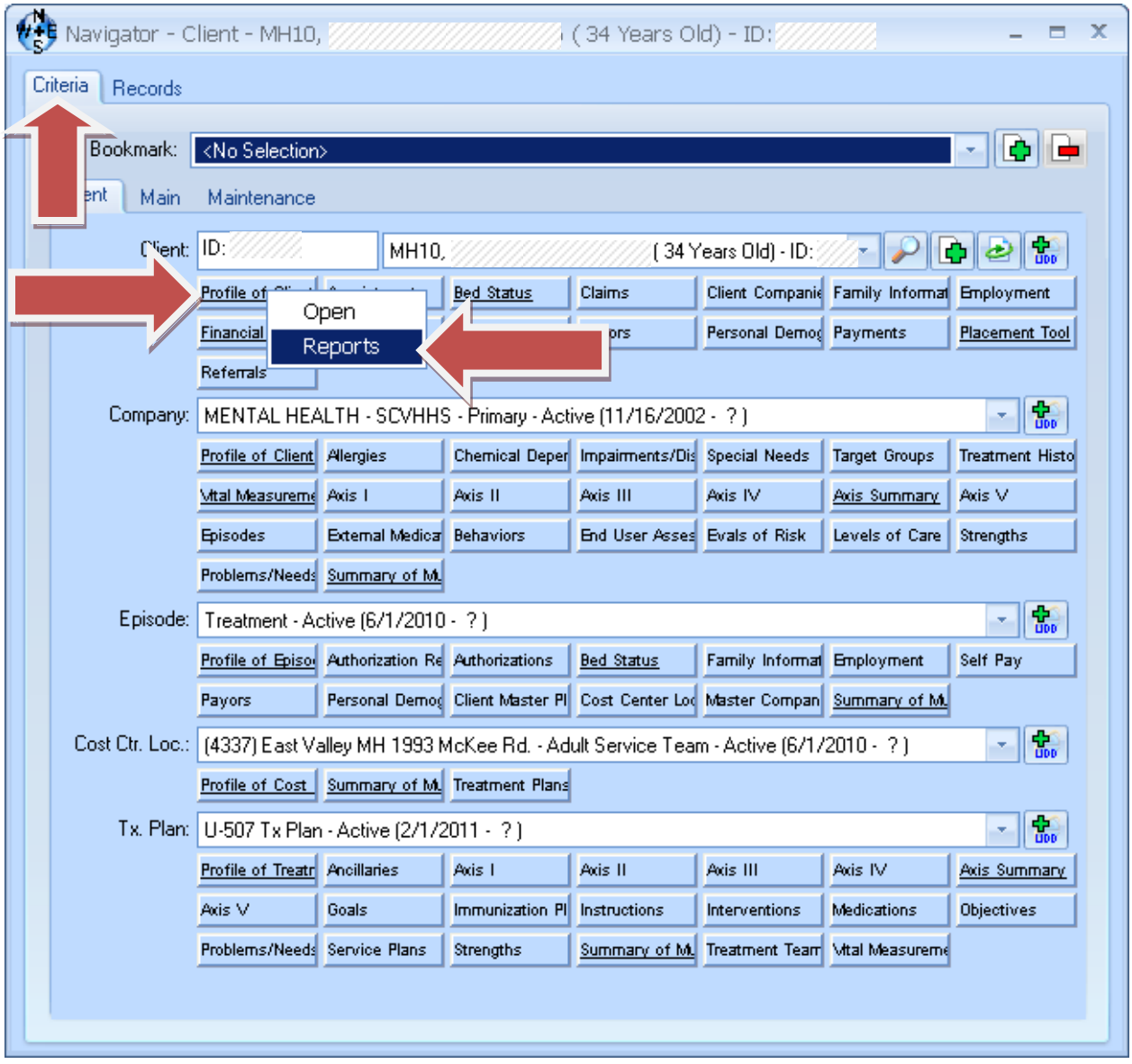
You are returned to the Recorded Service screen. If you have completed entering all of your data, click **Save** and you will be returned to the Navigator screen.



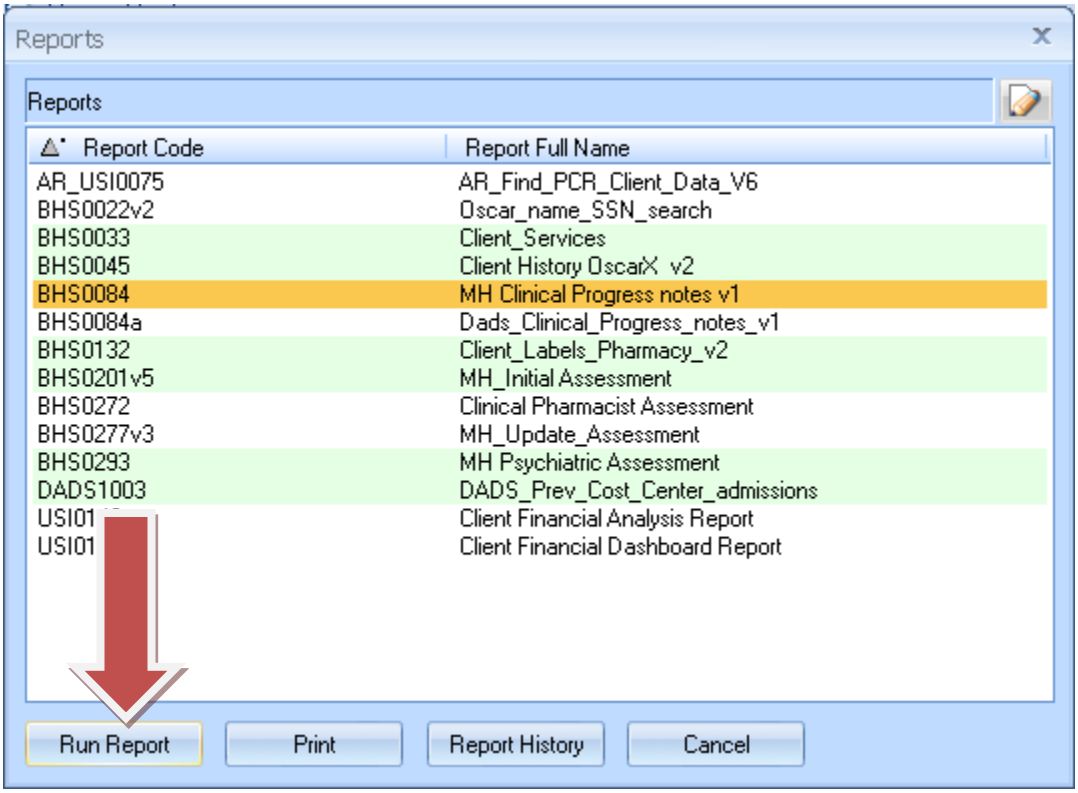
PRINTING A PROGRESS NOTE FROM NAVIGATOR

To print or view a progress note:

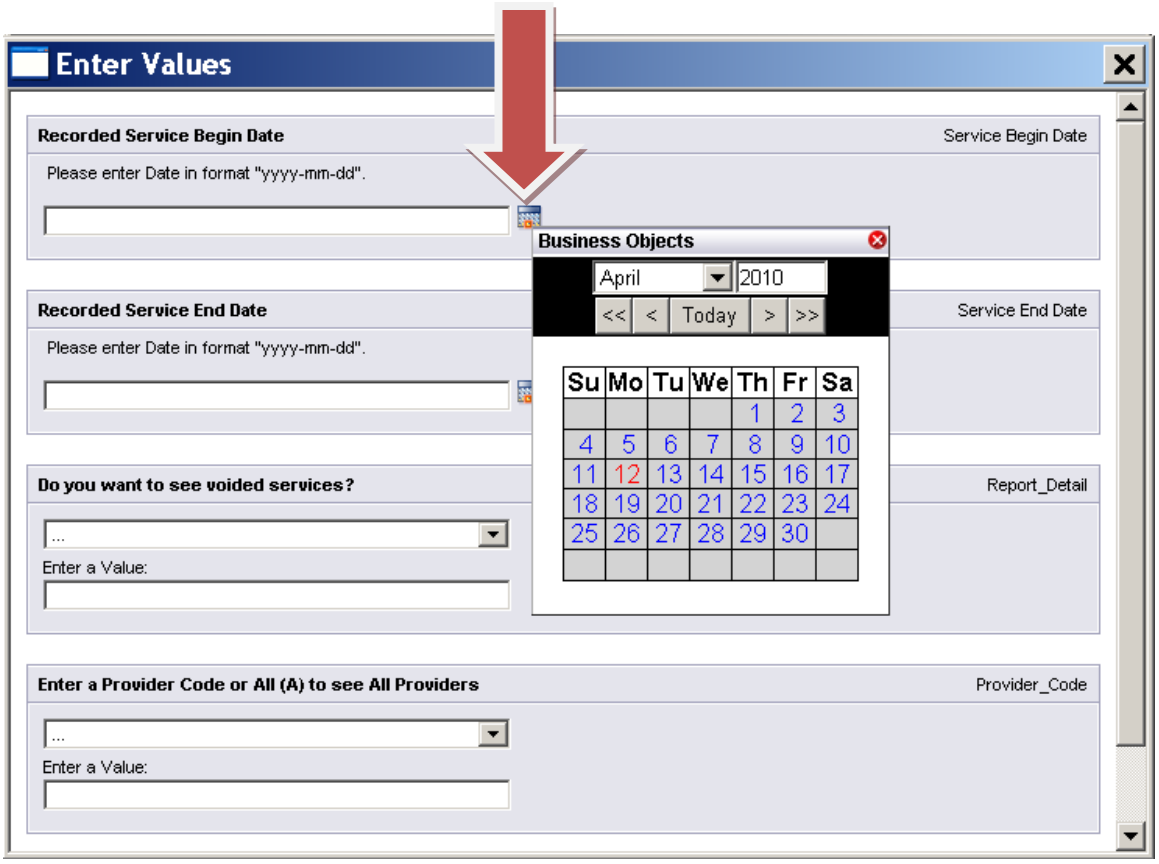
1. Click on the **Criteria** tab.
2. Right-click on **Profile of Client** and choose **Reports**.



Choose **BHS0084, MH Clinical Progress notes v1** and then click on **Run Report**.

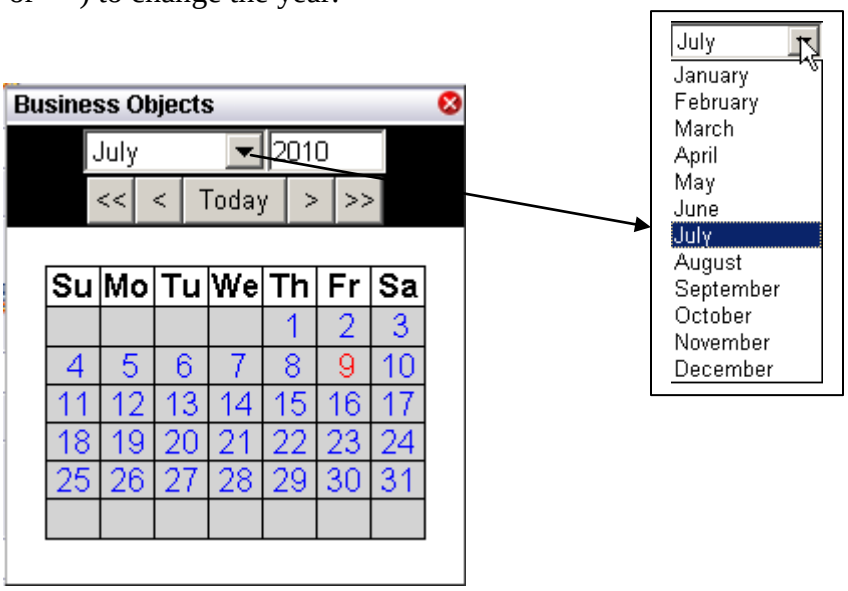


Recorded Service Begin Date: You need to enter the service date for the progress note you want printed. It is easiest to use the calendar at the right of the field.

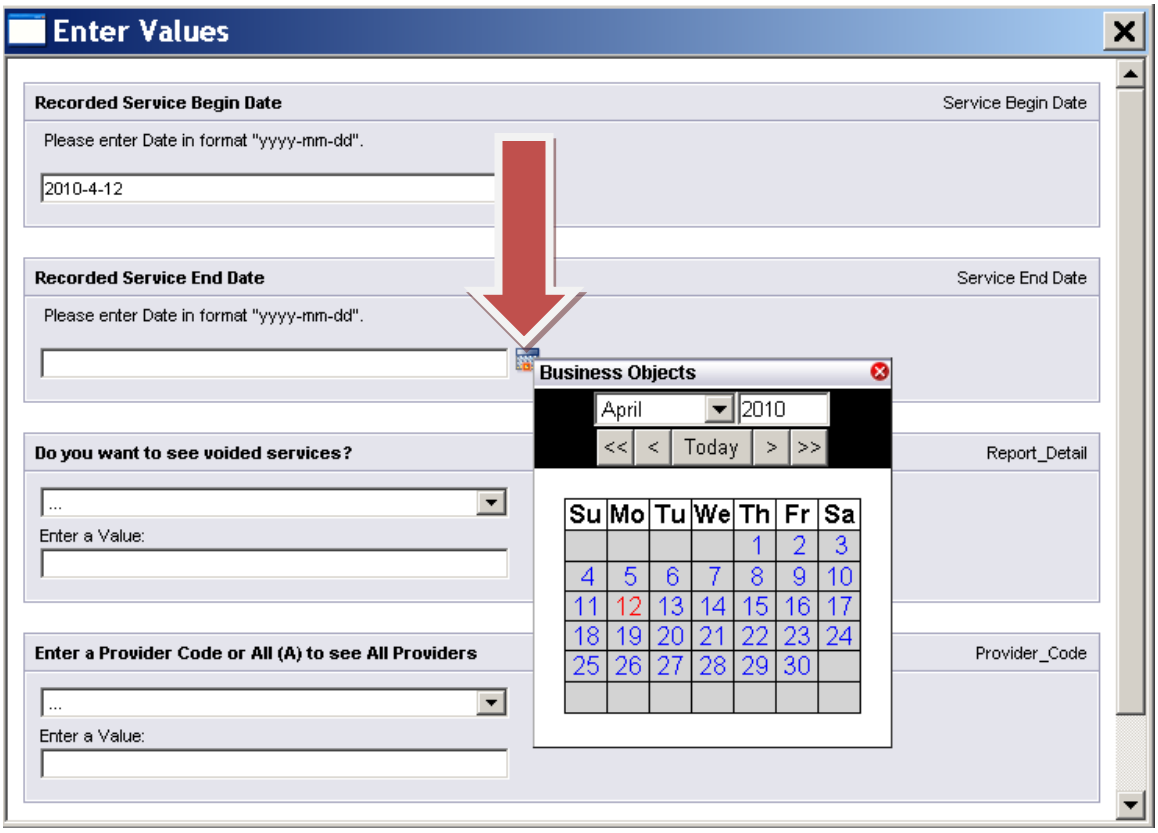

Enter Values
Recorded Service Begin Date
Service Begin Date
Please enter Date in format "yyyy-mm-dd".
Business Objects
April
2010
<< < Today > >>
Su Mo Tu We Th Fr Sa
1 2 3
4 5 6 7 8 9 10
11 12 13 14 15 16 17
18 19 20 21 22 23 24
25 26 27 28 29 30
Recorded Service End Date
Service End Date
Please enter Date in format "yyyy-mm-dd".
Do you want to see voided services?
Report_Detail
Enter a Value:
Enter a Provider Code or All (A) to see All Providers
Provider_Code
Enter a Value:

Calendar tips

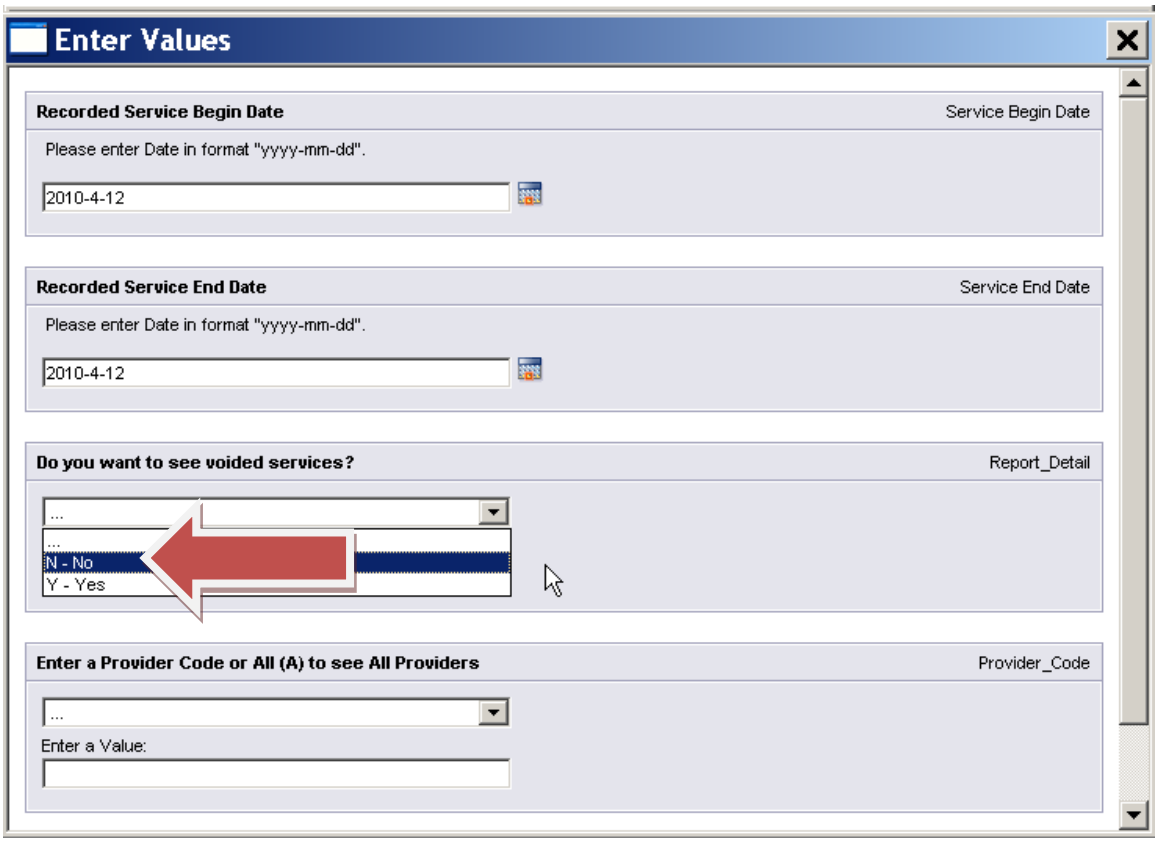
Use either the single arrows (< or >) or the dropdown menu to change the month.
Use the double arrows (<< or >>) to change the year.



Recorded Service End Date: This is usually the same date as above. If you cannot remember the exact progress note date, you can enter a range of dates. It will print all the progress notes between that date range.



Do you want to see voided services? Choose **No**, which means that voids will not be printed. You do not want voided progress notes in your chart.

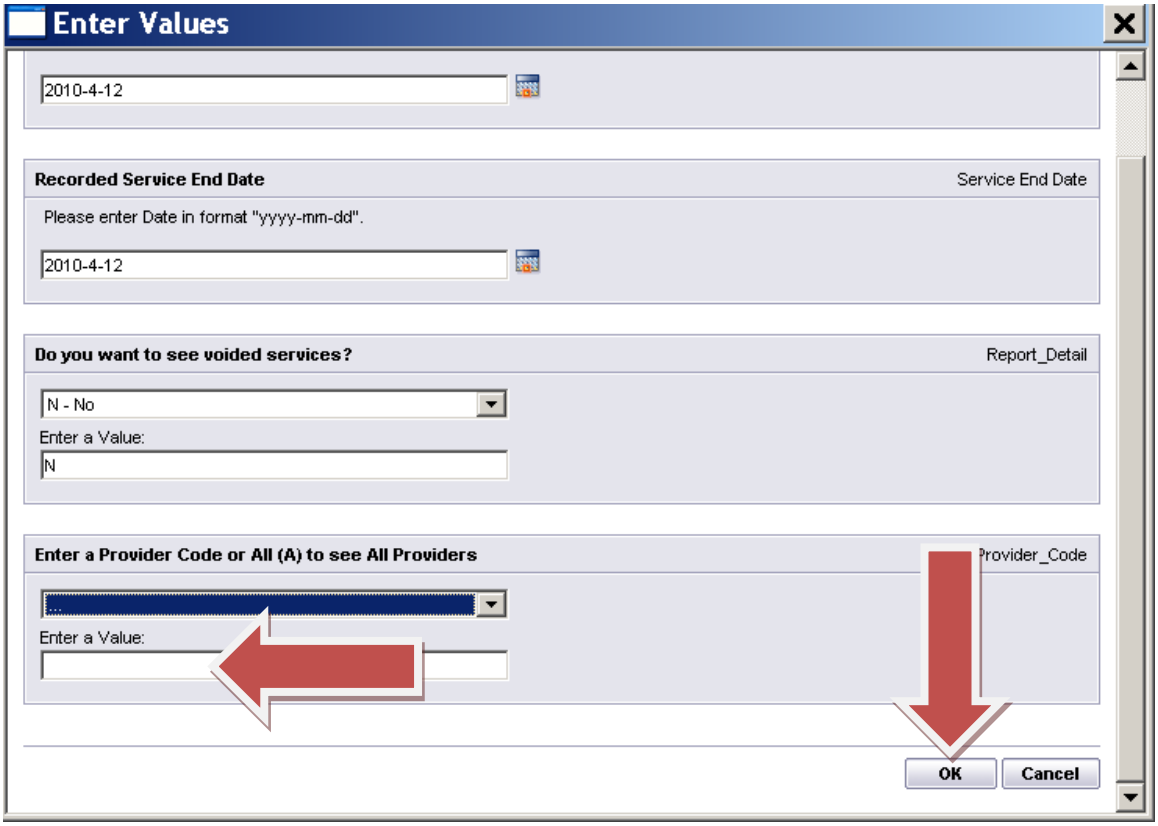


Enter a Provider Code or All (A) to see All Providers:

1. If you just want to see just your progress notes, then you must enter your Unicare Provider number in the Enter a Value field.
2. If you want to see all progress notes, choose All.

Note: You must enter the correct data in all four fields for your progress note to print.

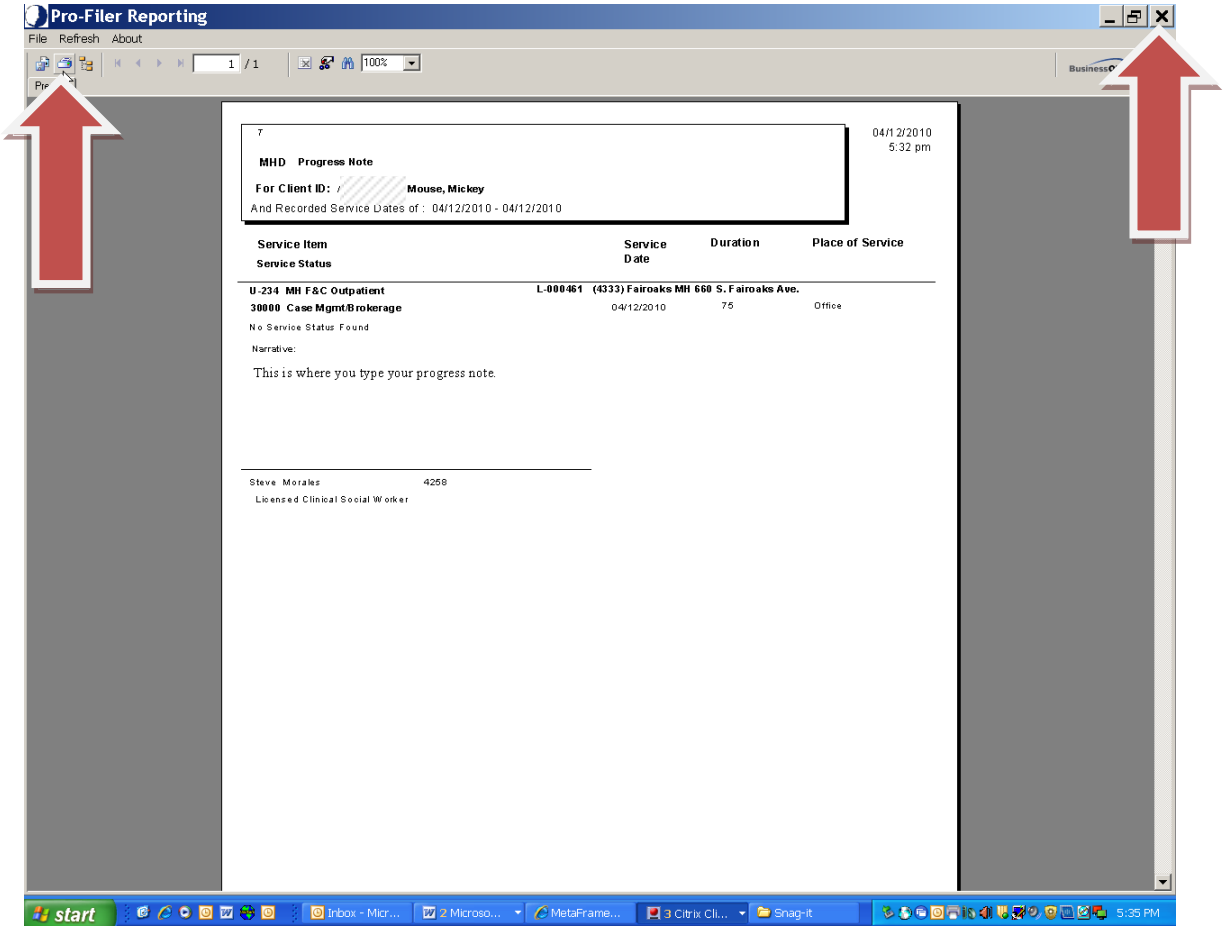
Click **OK** or press Enter on your keyboard when you are finished.



Click the **Printer icon** in the top left-hand corner.

After your progress note has been printed, please check to make sure that the service type, status, date and duration are correct. Then sign it and file it in the client's chart.

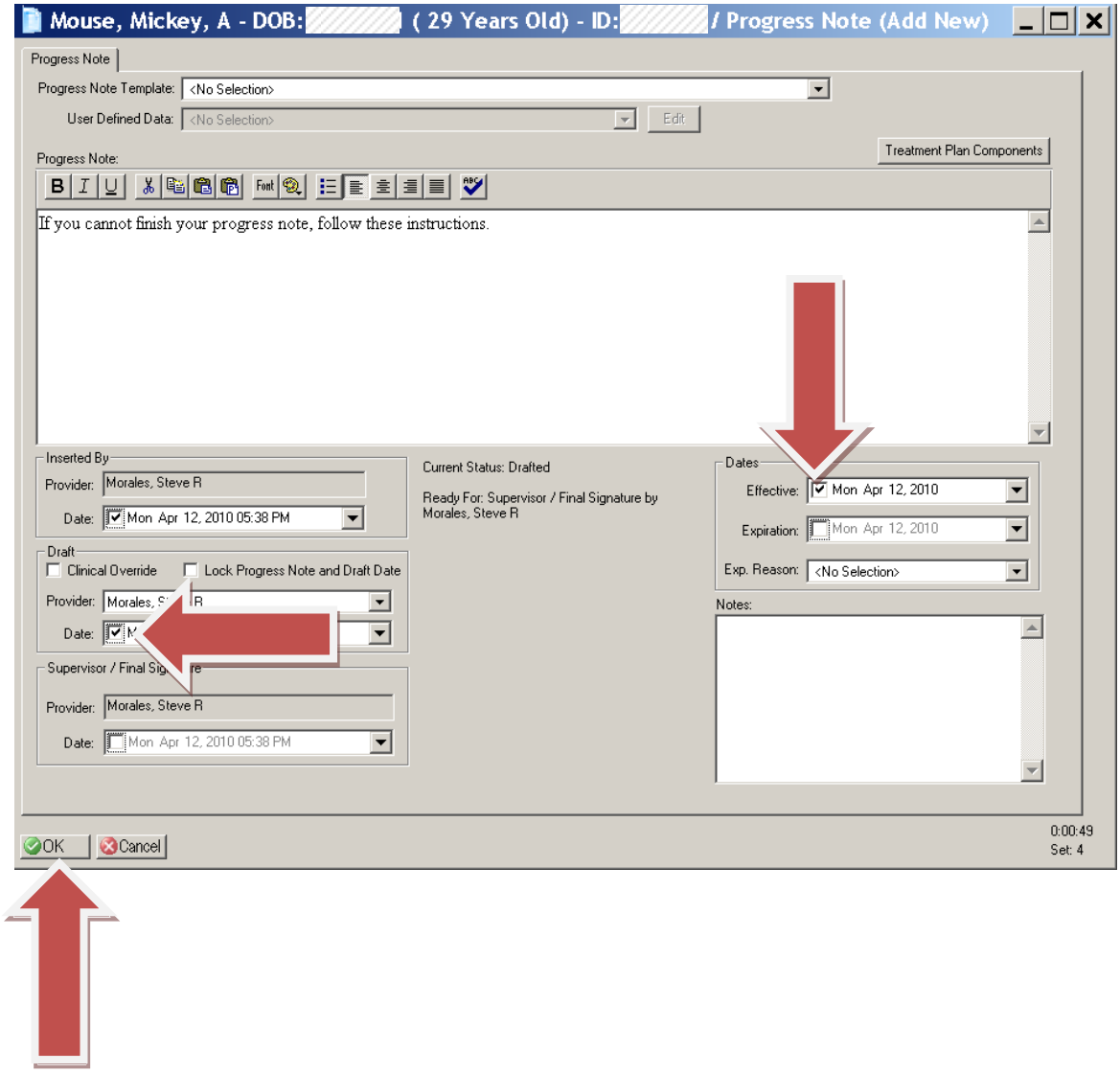
Note: Close a report screen by clicking on the X in the top right-hand corner.



SAVING A PARTIAL PROGRESS NOTE

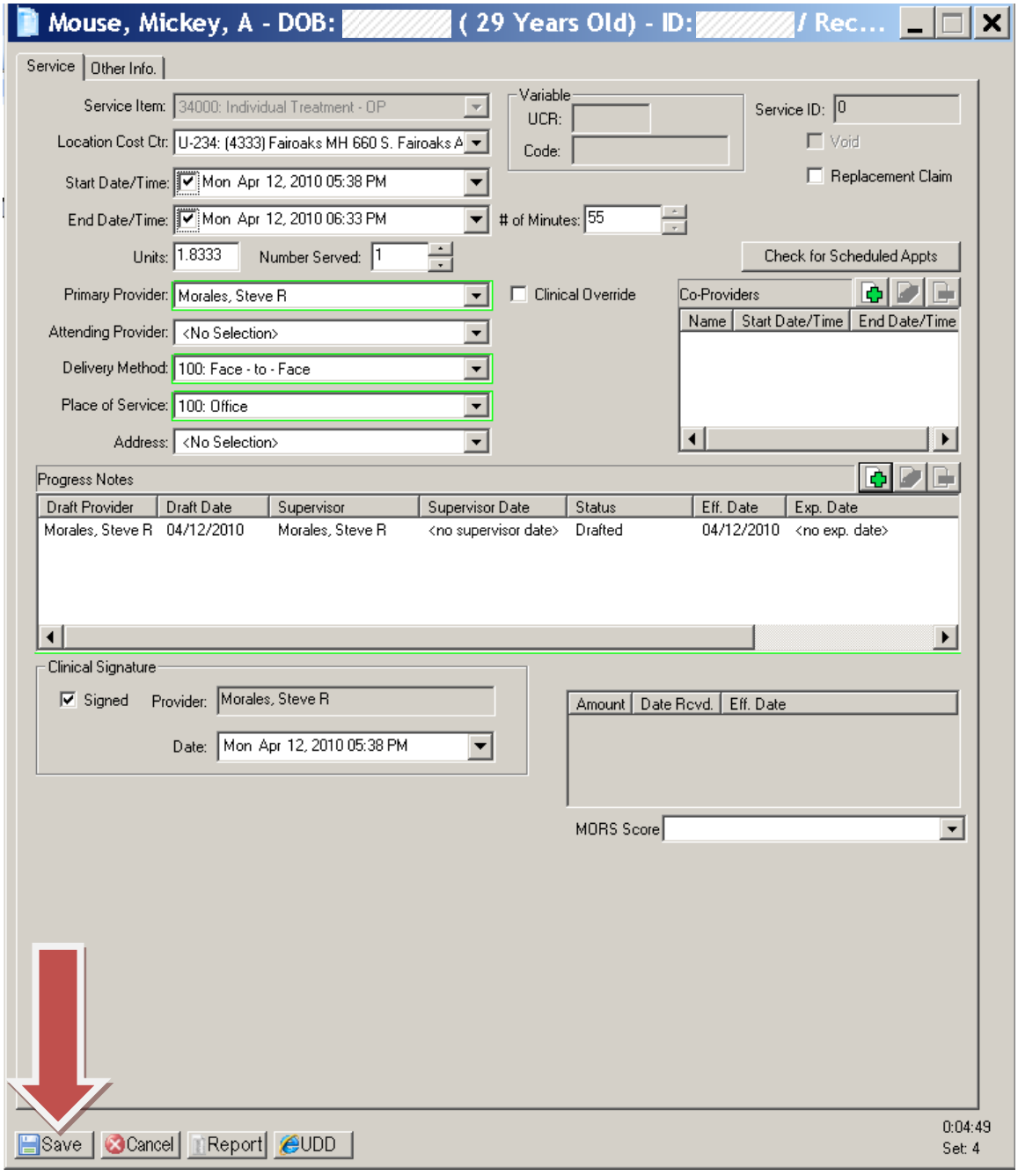
If you begin a progress note but cannot complete it, you can save a draft by following this procedure:

1. Click the **Effective Date** box.
2. Click the **Draft Date** box.
3. Click **OK.**



You are returned to the Recorded Service screen.

Click **Save** and you will be returned to the Navigator screen.

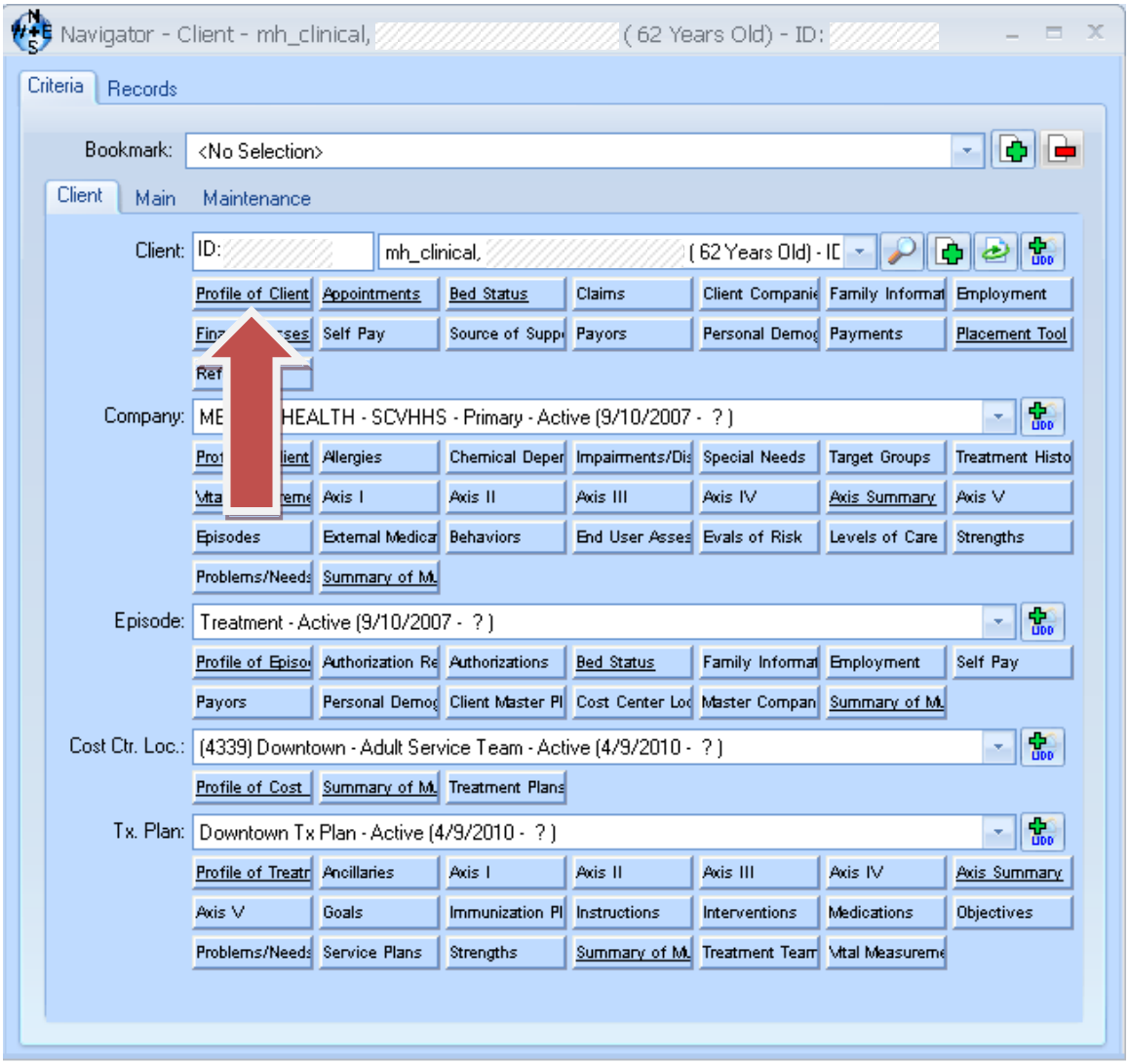


RETRIEVING A PARTIAL OR VIEWING COMPLETED PROGRESS NOTES

You have the capability to:

1. Review a recorded service and progress note that was saved as Final for any provider who recorded a service on your client.
2. Change and/or modify a progress note that you started if it was saved as a Provider Draft.

Click the **Profile of Client** button for the client's progress note that you need.



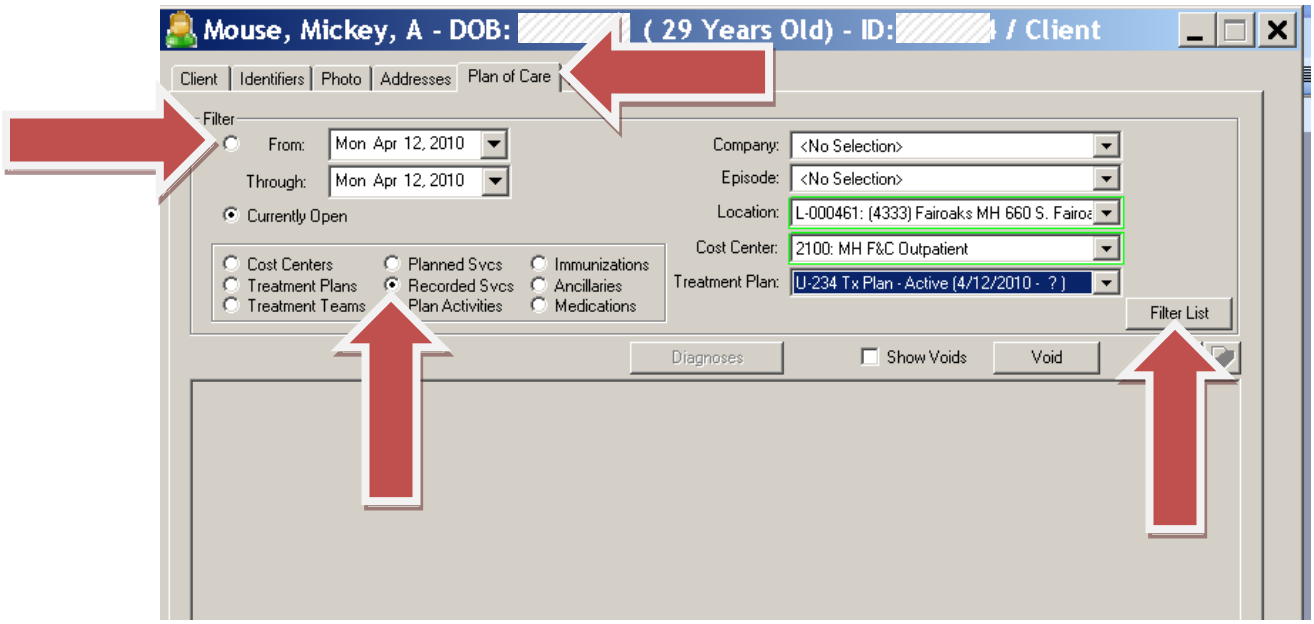
Click the Plan of Care tab.

If you are retrieving a progress note that you started earlier on the same day:

1. Click **Recorded Svcs.**
2. Click **Filter List**.

If you are retrieving a progress note from a day in the past:

1. Click on the radio button on the left side of **From**.
2. Enter either the exact date in both **From** and **Through** or a range of dates if you can't remember the exact date.
3. Click **Recorded Svcs.**
4. Click **Filter List**.

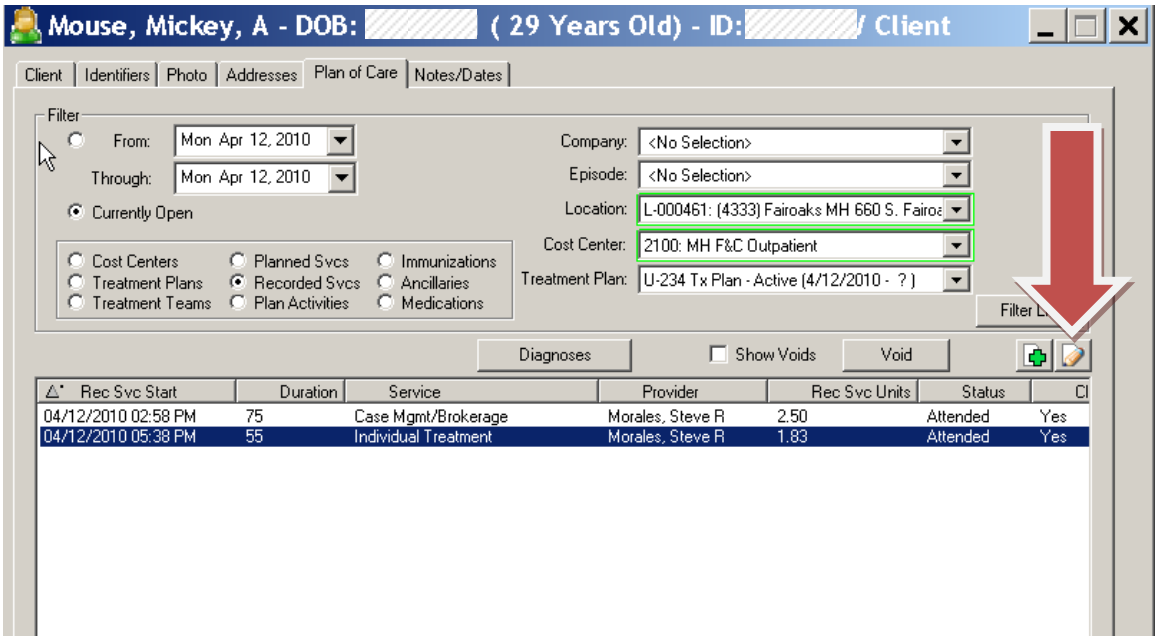


The following screen will be displayed.

Find the service you need and open it by double clicking it or single click it and then click on the **Edit icon** (yellow pencil).

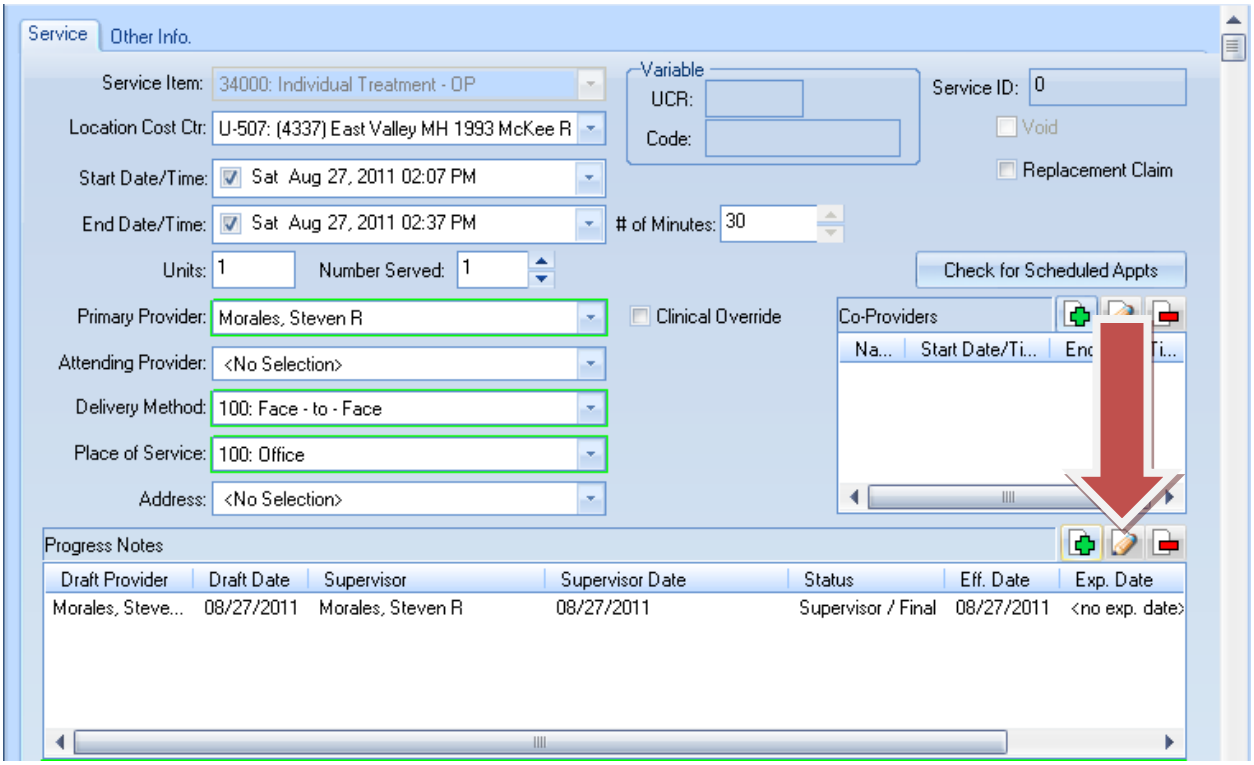
Note: Do not click on the Add Progress Note icon (green plus sign) or else you will start a new blank progress note instead of accessing your original draft progress note.

This will take you to the Recorded Service screen.



Your service now appears.

1. Double-click it or highlight it
2. Click the **Edit icon** (yellow pencil)

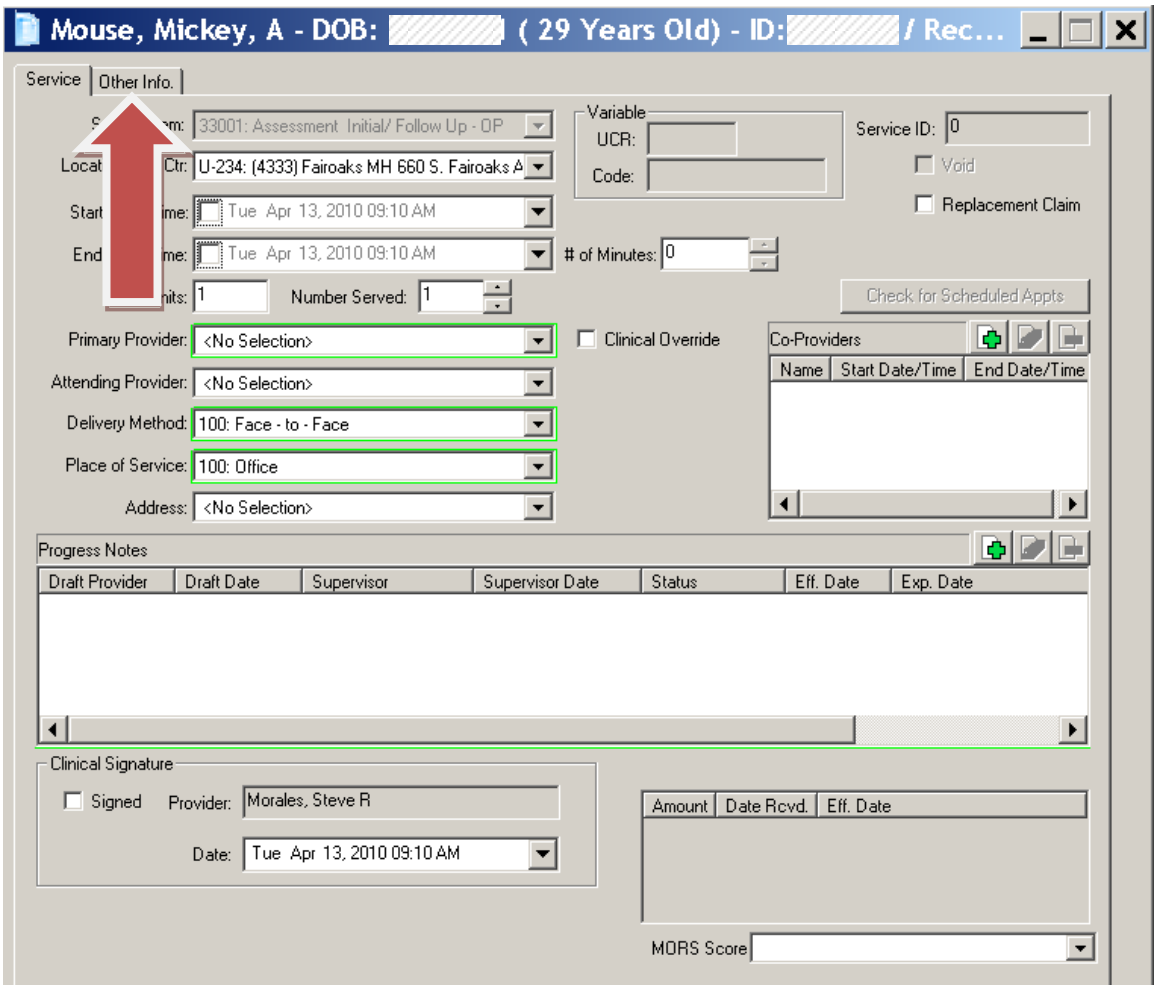


Your partial progress note appears. Click in the progress note field where you left off and begin typing. When you are finished, click the Final Signature date box and then OK.

RECORDING SERVICE STATUS

If you are recording an **Assessment or Collateral** service, you must also record a Service Status code. This is accomplished by using the **Other Info** tab on the Recorded Service screen.

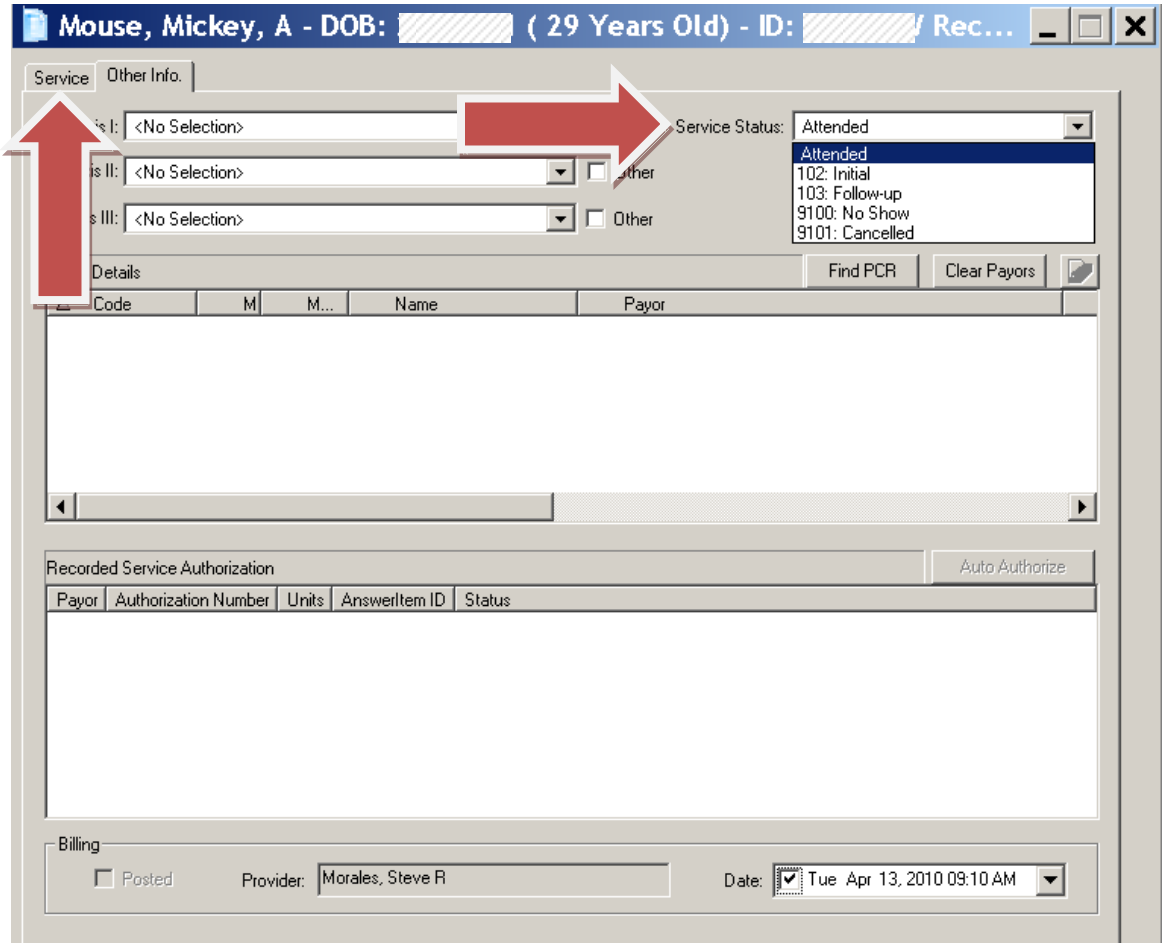
Click the **Other Info** tab.



For **Assessment Initial/Follow-up** services:

1. Click on the dropdown arrow at the **Service Status** field and choose:
   - Initial – choose this for the first session during the intake process when the client is brand new to our County's Mental Health system. Also choose this if the client has been closed to our system for more than six months.
   - Follow-up – choose this for subsequent sessions during the intake process and for annual assessments.

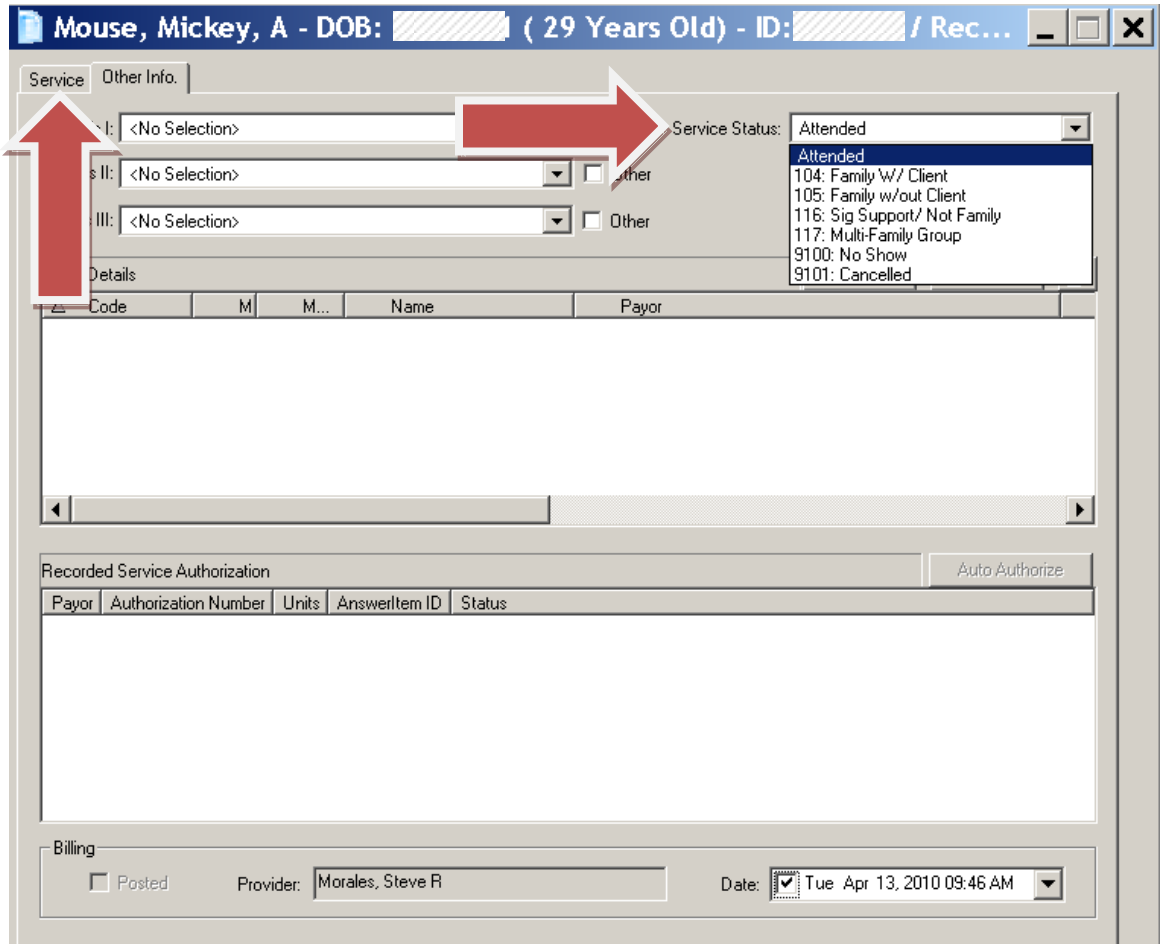
2. After you make your choice, click back to the **Service** tab and resume your data entry.



For **Collateral** services:

1. Click on the dropdown arrow at the **Service Status** field and choose:
   - Family w/client (family with client)
   - Family w/out client (family without client)
   - Sig Support/not fam (significant support person not family)
   - Multi-Family Group

2. After you make your choice, click back to the **Service** tab and resume your data entry.



RECORDING NO SHOW AND CANCELLED APPOINTMENTS

No shows and cancelled appointments need to be recorded into Unicare as an Activity with 0 (zero) minutes of service.

A No Show is defined as:

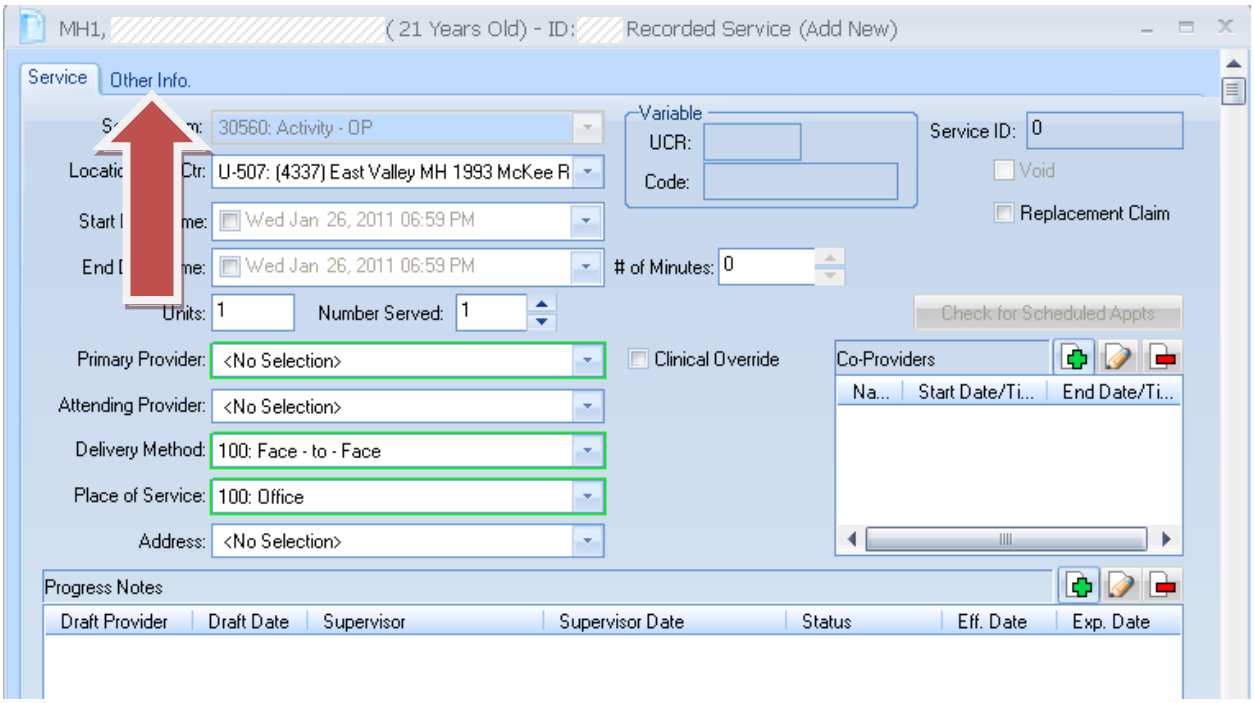
- A client or significant support person that does not show to a scheduled appointment.
- A client or significant support person arrives so late that the provider decides that they cannot see the client for any services.

A Cancelled appointment is defined as:

- A client, significant support person or provider calling to cancel a scheduled appointment.

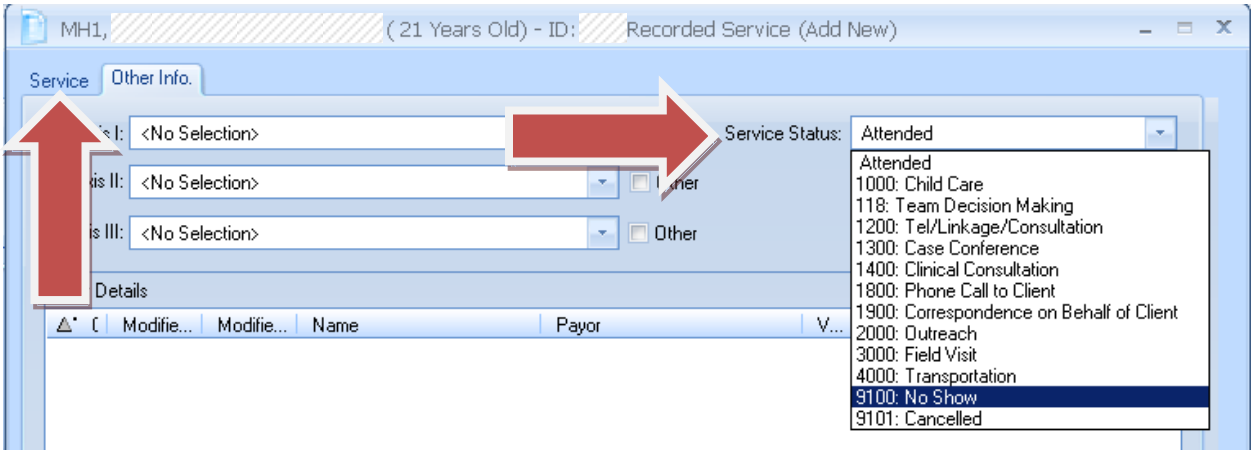
On the **Recorded Service** screen, the **Other Info** tab in the top left-hand corner is used to record a **Service Status** for Assessment, MD Assessment and Collateral services. This is where No Show and Cancelled will also be recorded.

Click on the **Other Info** tab.



Click on the **Service Status** dropdown menu and you will see No Show and Cancelled. Click on the appropriate choice. Click back to the **Service** tab and continue filling out the screen as usual.

Note: An EBP/SS or Multiple Service Code is not necessary.



If you call the client to find out why they did not show or cancelled, there are two options:

1. No one answers, so you leave a message, if you can. Please write a short progress note about your telephone call with your Activity service. This is the only service you need to record. Again, you must enter 0 (zero) minutes on the Recorded Service screen.

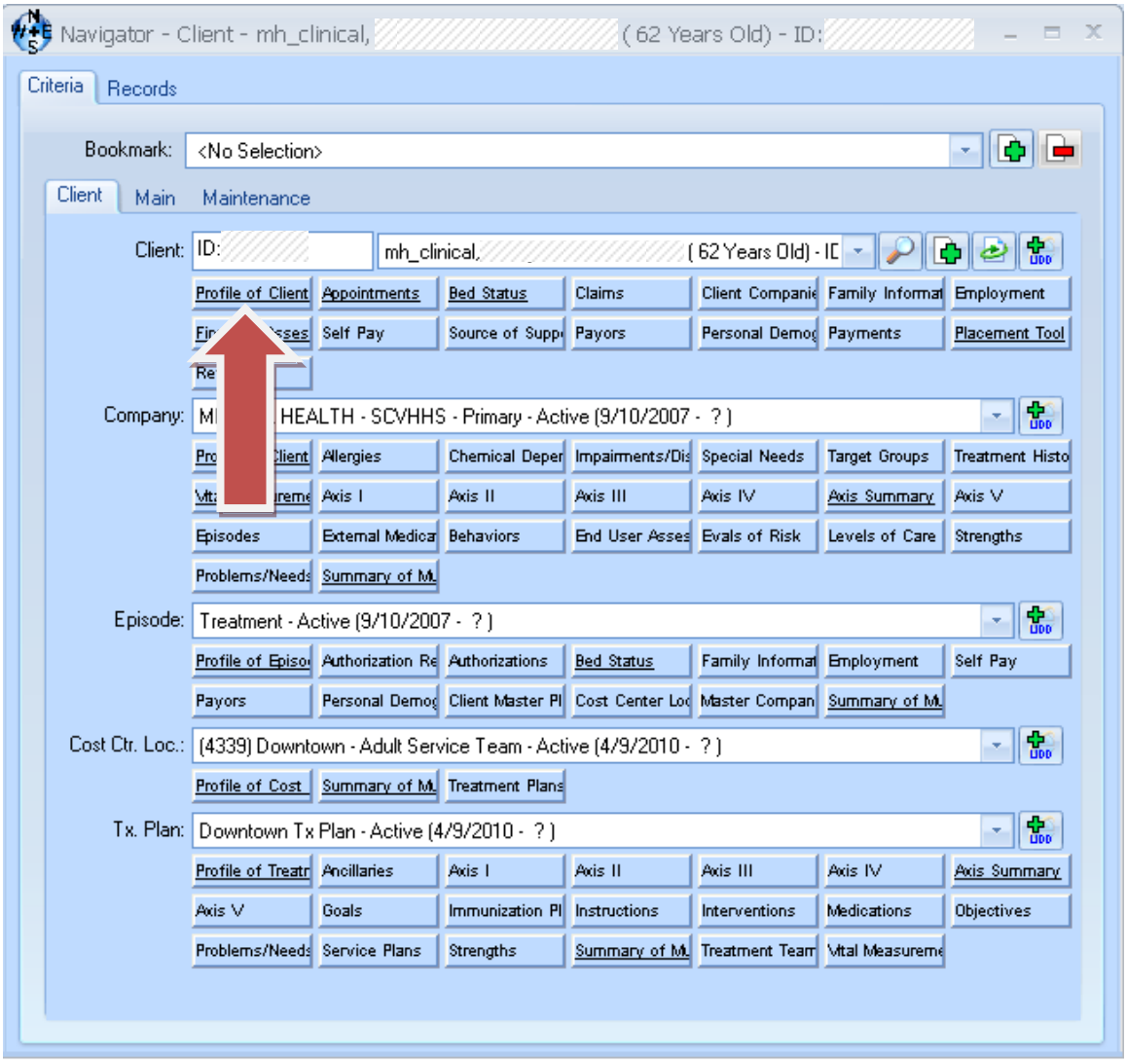
   Note: If you listen to a voice message regarding a cancelled appointment, then this would be recorded as Cancelled under Activity.

2. You talk with someone and this leads to a billable service such as Case Management. In this situation, you would be required to record both an Activity service for the No Show/Cancelled and the billable service.

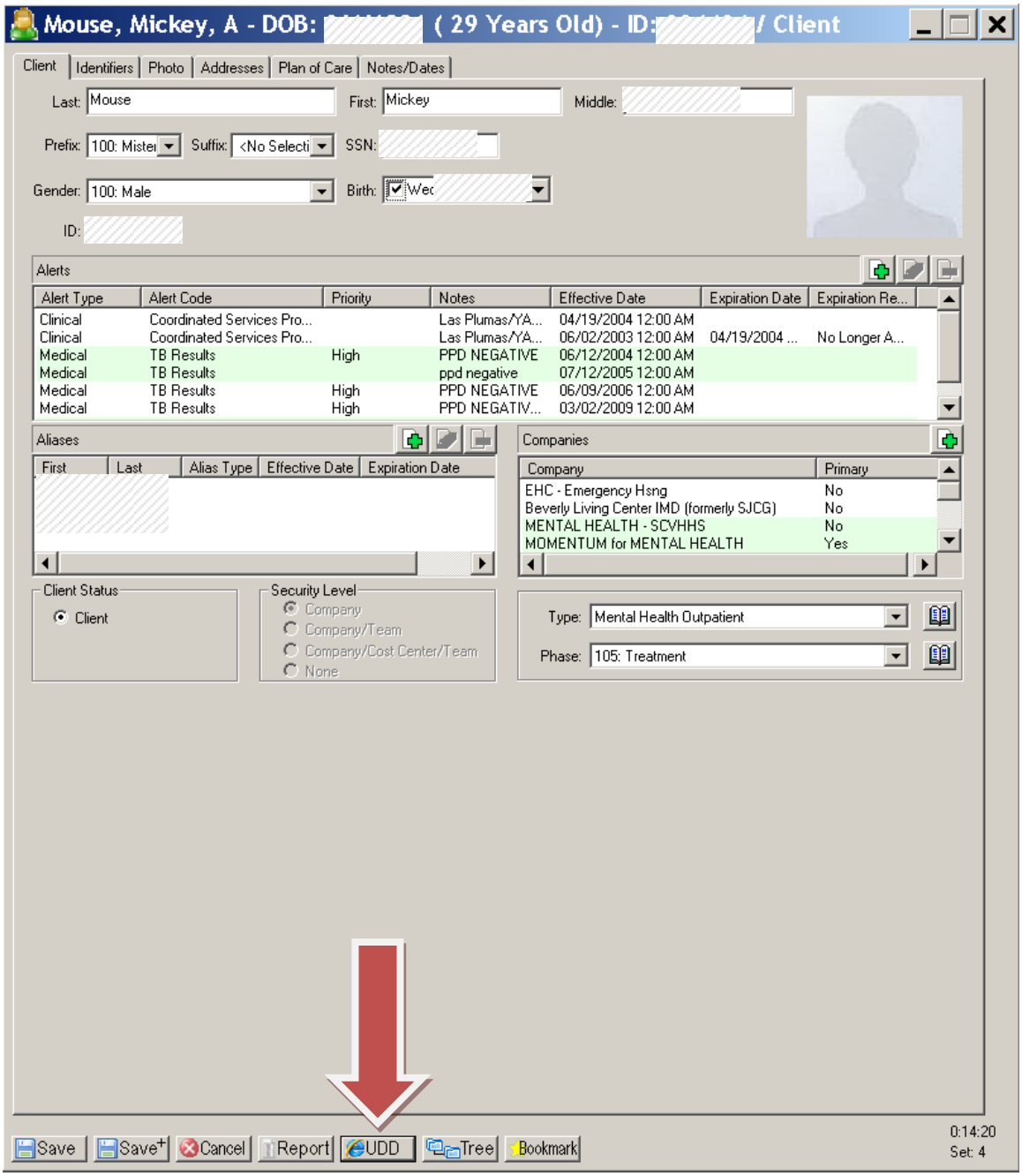
RECORDING AN INITIAL ASSESSMENT

Both the Initial and Update Assessments are documented using Unicare.

From the Navigator screen, find your client and then click the **Profile of Client** button.



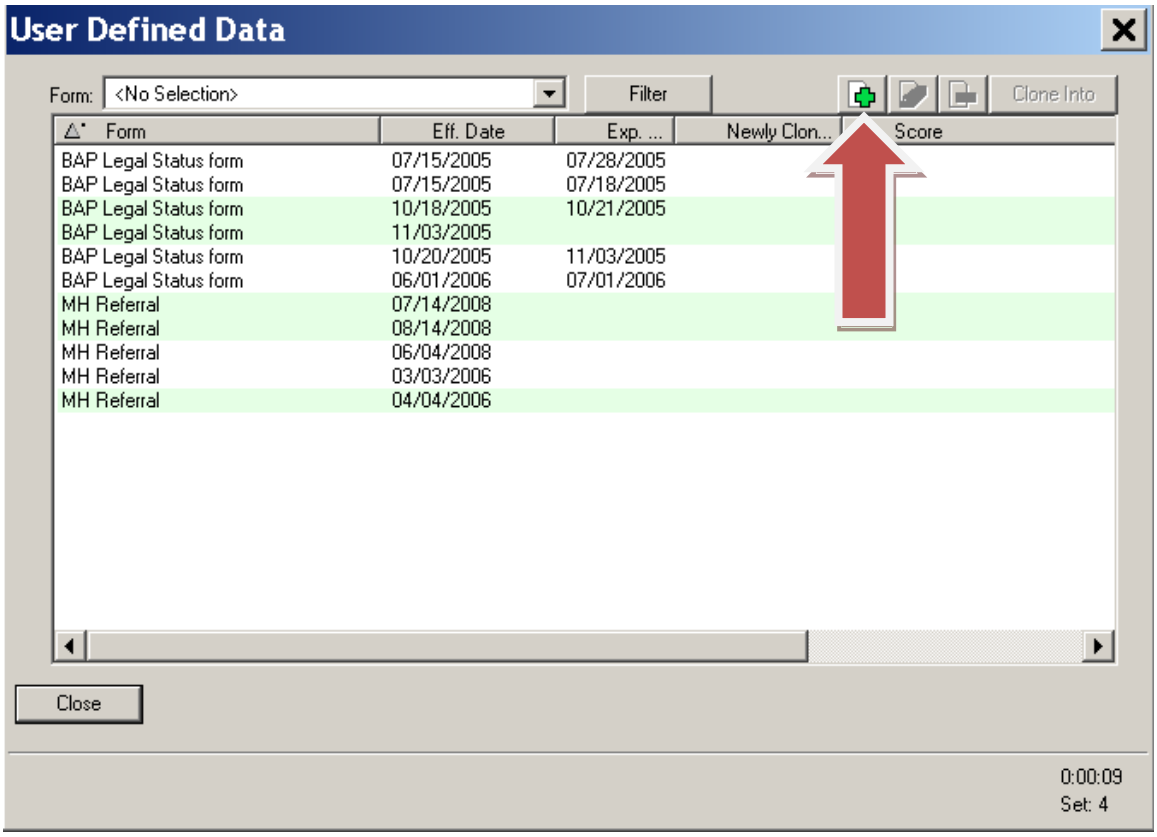
Click the **UDD** button at the bottom.



The UDD screen will appear.

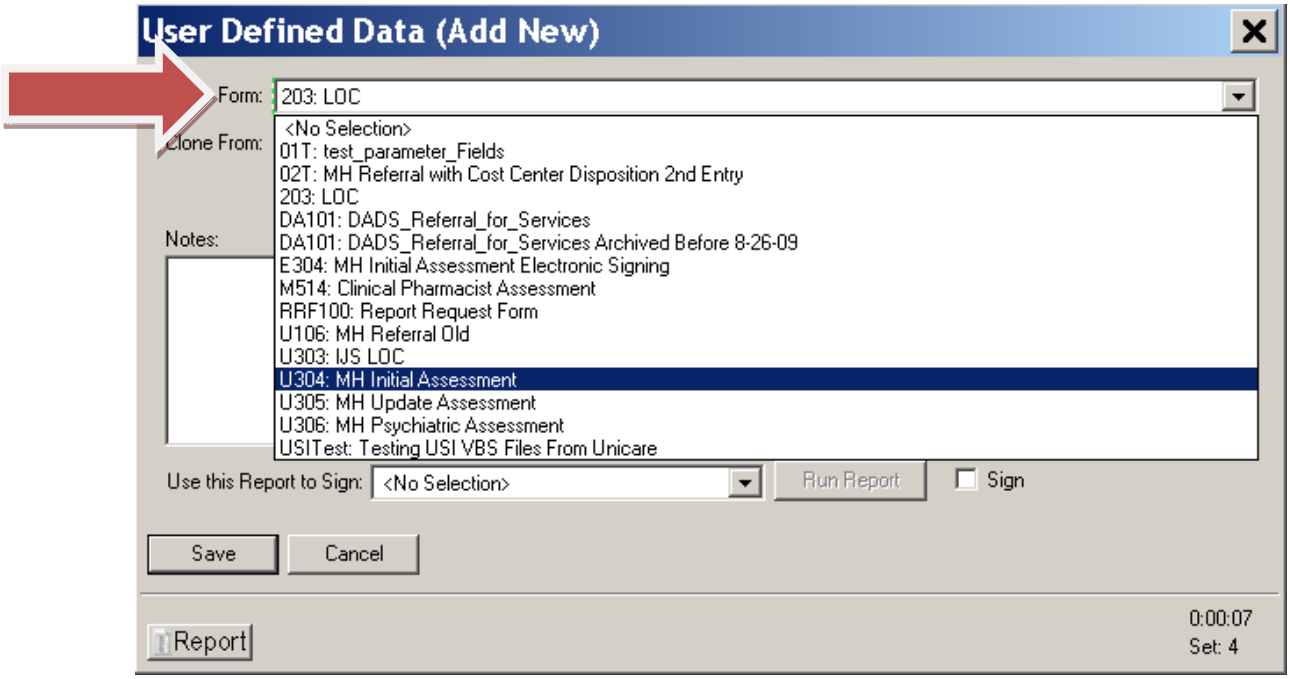
Click the **Add New icon**.

Note: There could be other forms on this screen.

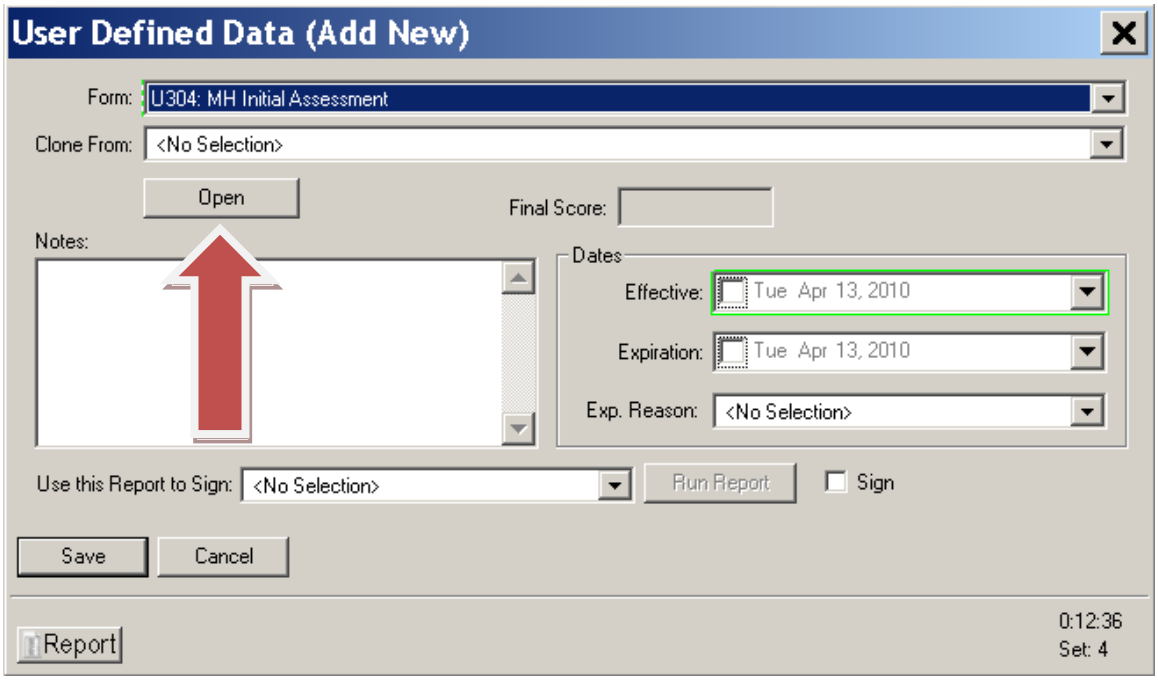


The Add New screen will appear.

In the **Form** field, click on the dropdown arrow and choose **U304: MH Initial Assessment.**



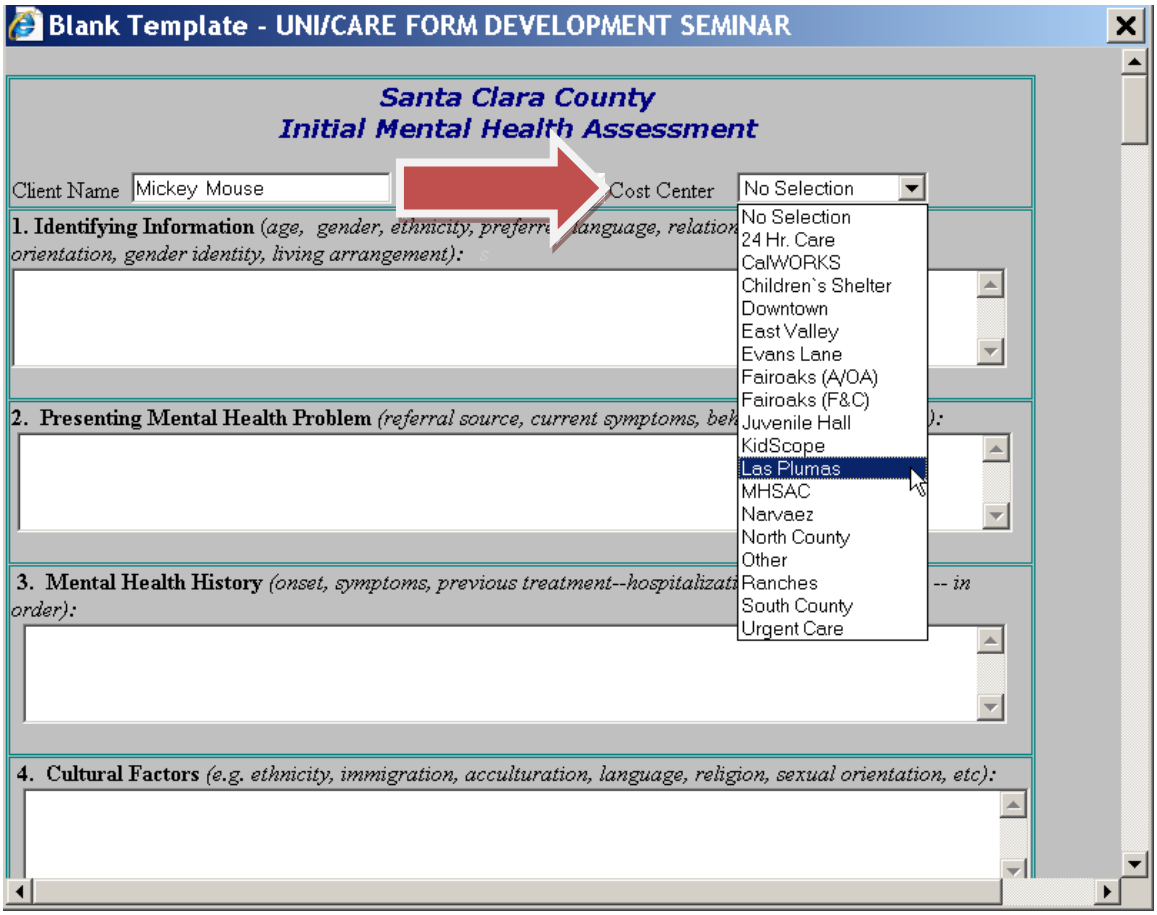
Click **Open**.


User Defined Data (Add New)
Form:
U304: MH Initial Assessment
Clone From:
<No Selection>
Open
Final Score:
Notes:
Dates
Effective:
Tue Apr 13, 2010
Expiration:
Tue Apr 13, 2010
Exp. Reason:
<No Selection>
Use this Report to Sign:
<No Selection>
Run Report
Sign
Save
Cancel
Report
0:12:36
Set: 4

The Initial Assessment form will appear. Your client's name and Unicare number are automatically filled in.

Start filling out the form by choosing your **Cost Center**.

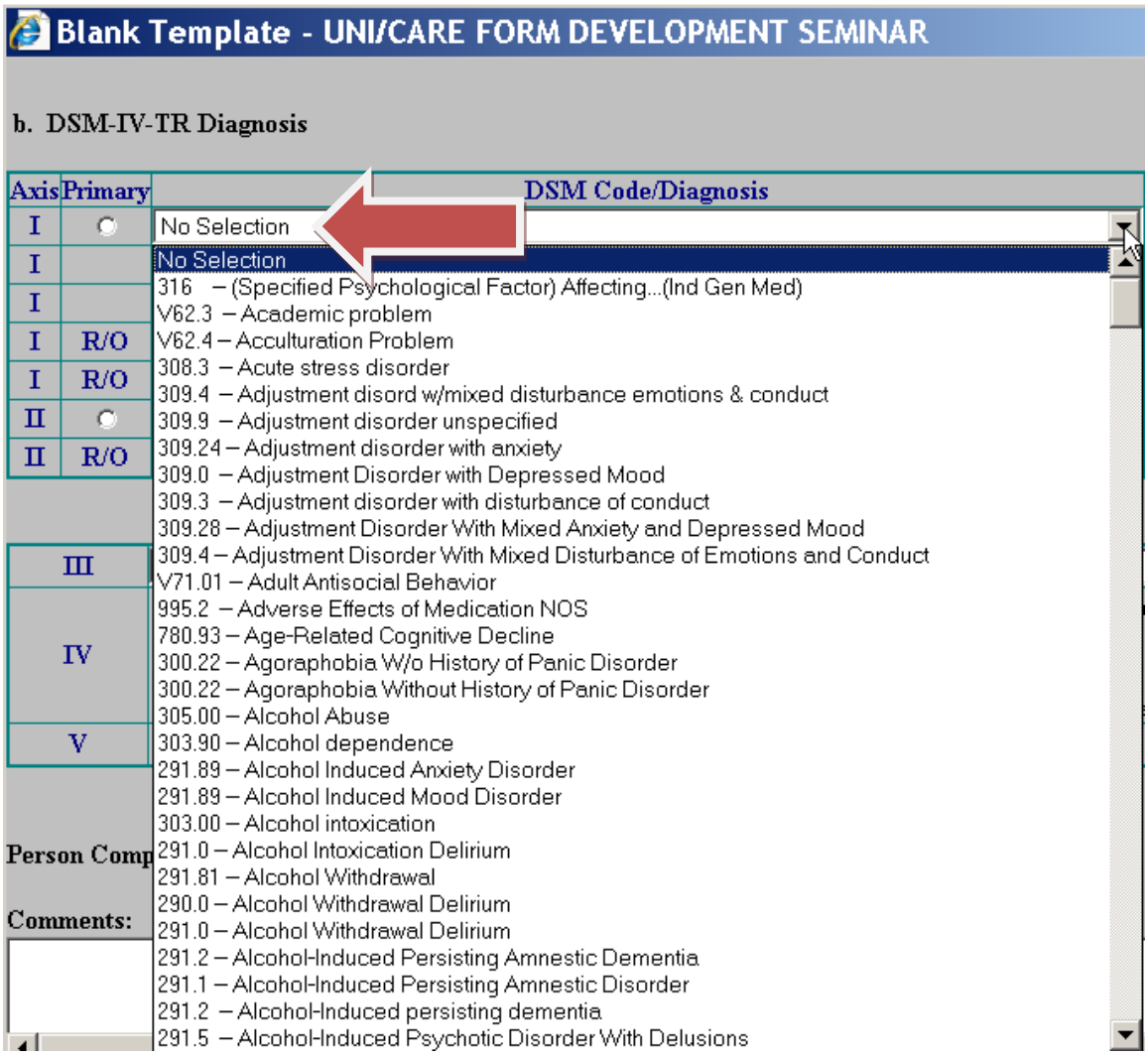
Continue filling out the rest of the form. You can type as much information as needed in most fields.



Towards the end of the form, you will come to the diagnosis fields. You will notice that all of the DSM diagnoses for Axis I and II are in alphabetical order. You must choose your diagnoses before choosing the Primary diagnosis.

You must choose a **Primary Diagnosis** in either Axis I or II or you will not be able to save your work as Final. Do this by clicking on the appropriate Primary box.

You also must fill out Axis III, IV and V or Unicare will not allow you to save as Final. You will get a pop-up message stating what needs to be filled out.

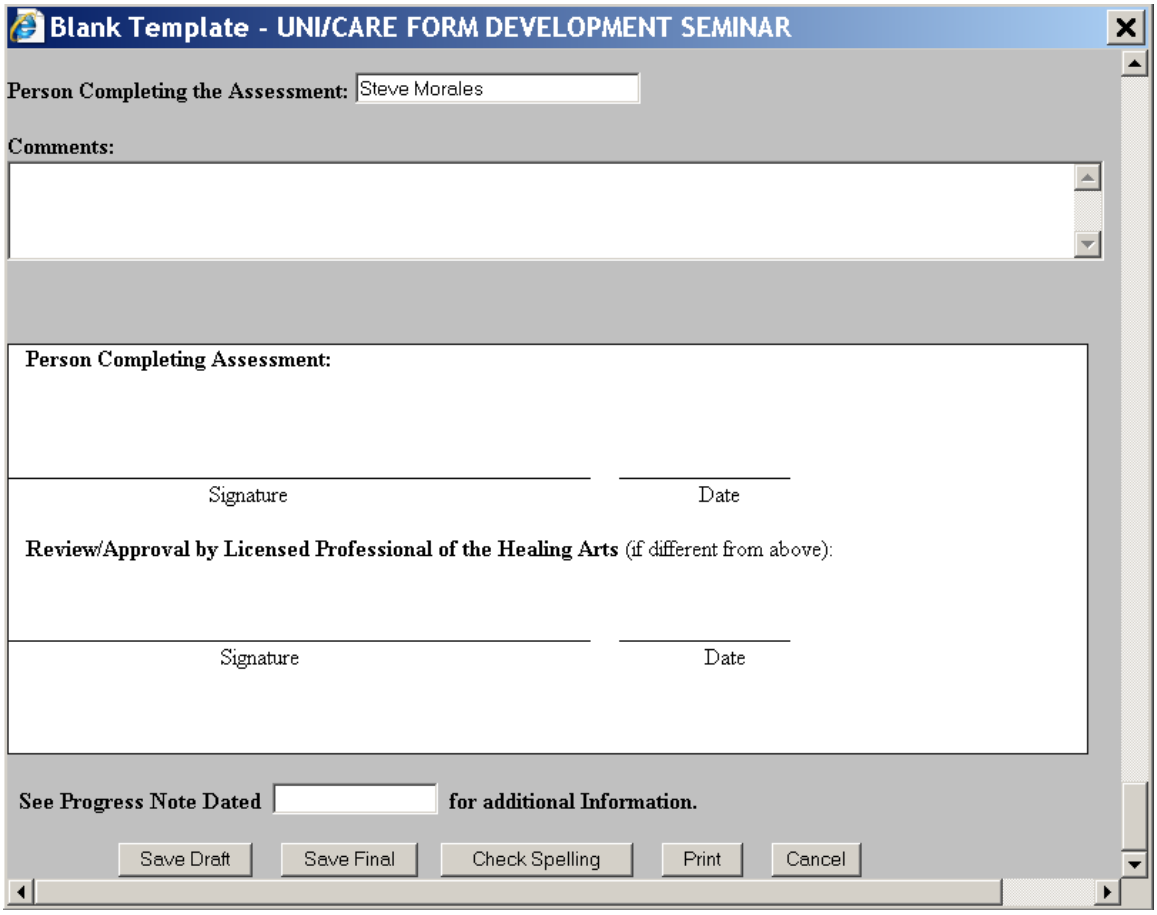

Blank Template - UNI/CARE FORM DEVELOPMENT SEMINAR
b. DSM-IV-TR Diagnosis
Axis
Primary
DSM Code/Diagnosis
I
I
I
I
R/O
I
R/O
II
II
R/O
III
IV
V
No Selection
No Selection
316 – (Specified Psychological Factor) Affecting...(Ind Gen Med)
V62.3 – Academic problem
V62.4 – Acculturation Problem
308.3 – Acute stress disorder
309.4 – Adjustment disord w/mixed disturbance emotions & conduct
309.9 – Adjustment disorder unspecified
309.24 – Adjustment disorder with anxiety
309.0 – Adjustment Disorder with Depressed Mood
309.3 – Adjustment disorder with disturbance of conduct
309.28 – Adjustment Disorder With Mixed Anxiety and Depressed Mood
309.4 – Adjustment Disorder With Mixed Disturbance of Emotions and Conduct
V71.01 – Adult Antisocial Behavior
995.2 – Adverse Effects of Medication NOS
780.93 – Age-Related Cognitive Decline
300.22 – Agoraphobia W/o History of Panic Disorder
300.22 – Agoraphobia Without History of Panic Disorder
305.00 – Alcohol Abuse
303.90 – Alcohol dependence
291.89 – Alcohol Induced Anxiety Disorder
291.89 – Alcohol Induced Mood Disorder
303.00 – Alcohol intoxication
291.0 – Alcohol Intoxication Delirium
291.81 – Alcohol Withdrawal
290.0 – Alcohol Withdrawal Delirium
291.0 – Alcohol Withdrawal Delirium
291.2 – Alcohol-Induced Persisting Amnestic Dementia
291.1 – Alcohol-Induced Persisting Amnestic Disorder
291.2 – Alcohol-Induced persisting dementia
291.5 – Alcohol-Induced Psychotic Disorder With Delusions
Person Comp
Comments:

There are various buttons at the bottom of the form:

- Save Draft – this will save a draft as many times as you need to
- Save Final – this will save the form permanently. You will not be able to edit the form after clicking this button.
- Check Spelling – this works like any other spell checker. Right clicking will not work.
- Print – this will print your form but not in the correct manner.
- Cancel – this will close the form but not save any new data that you have typed in since the last save.

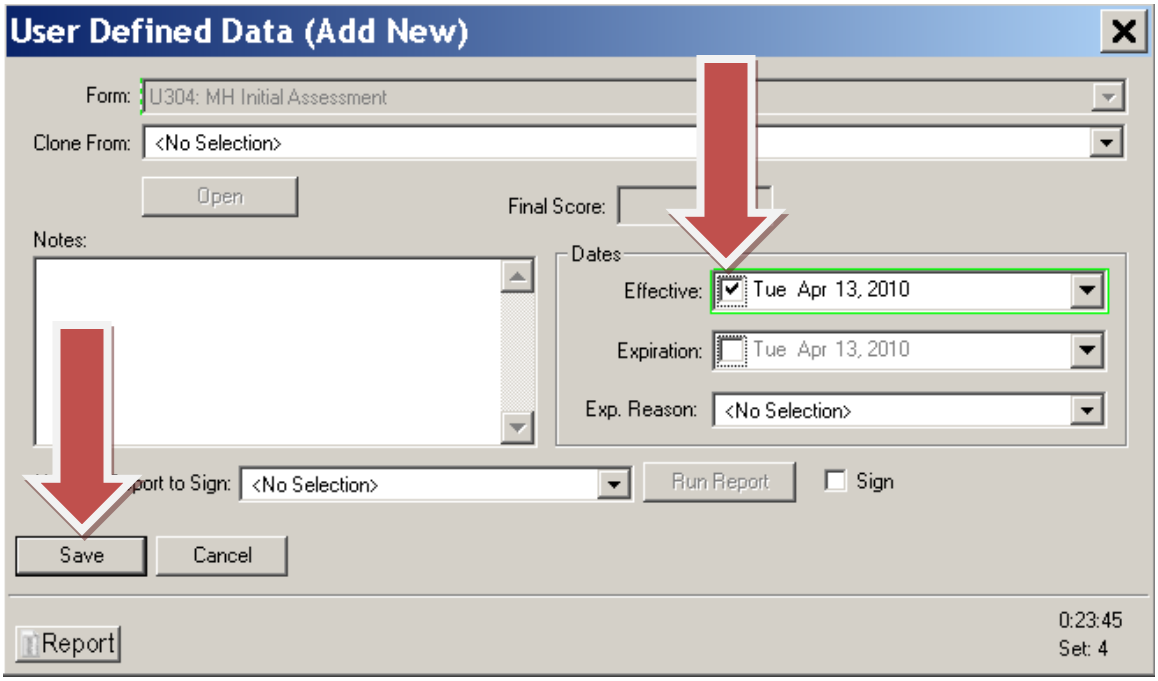
When you have completed filling out the form, click **Save Final**.

Note: Initial and Update Assessments must be saved as Final within 60 days of opening.



You will be brought back to the Add New screen.

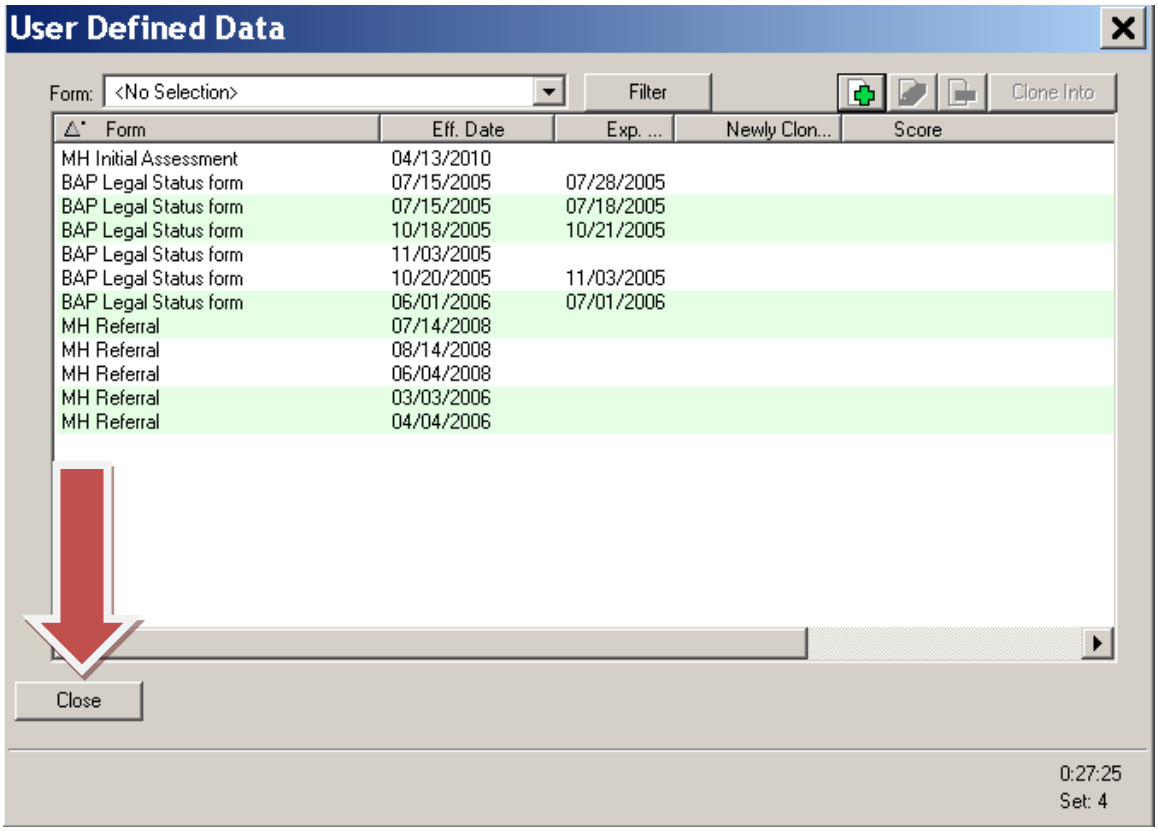
1. Click the **Effective Date** box. The effective date is the first day that the initial assessment by face-to-face was actually performed. Change the date if necessary.
2. Click **Save**.



Wait for your MH Initial Assessment to show up in the Form field, and then click **Close**.

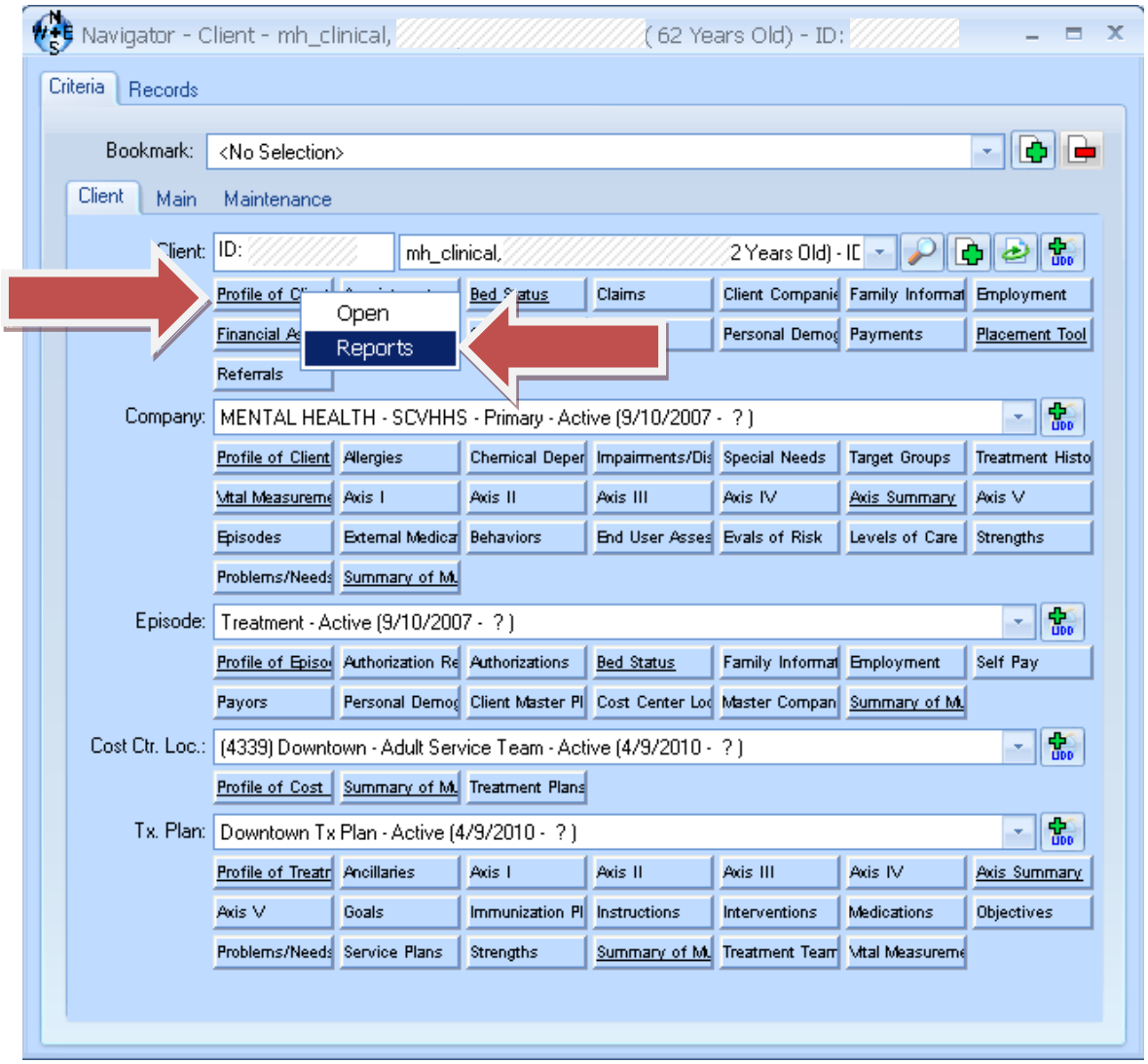
You can now go to your **Service Plans** button from your Navigator screen, record your Assessment service and write a progress note.

Note: Doing the Initial Assessment online <u>does not</u> automatically record the service <u>nor is it a substitute</u> for a progress note.

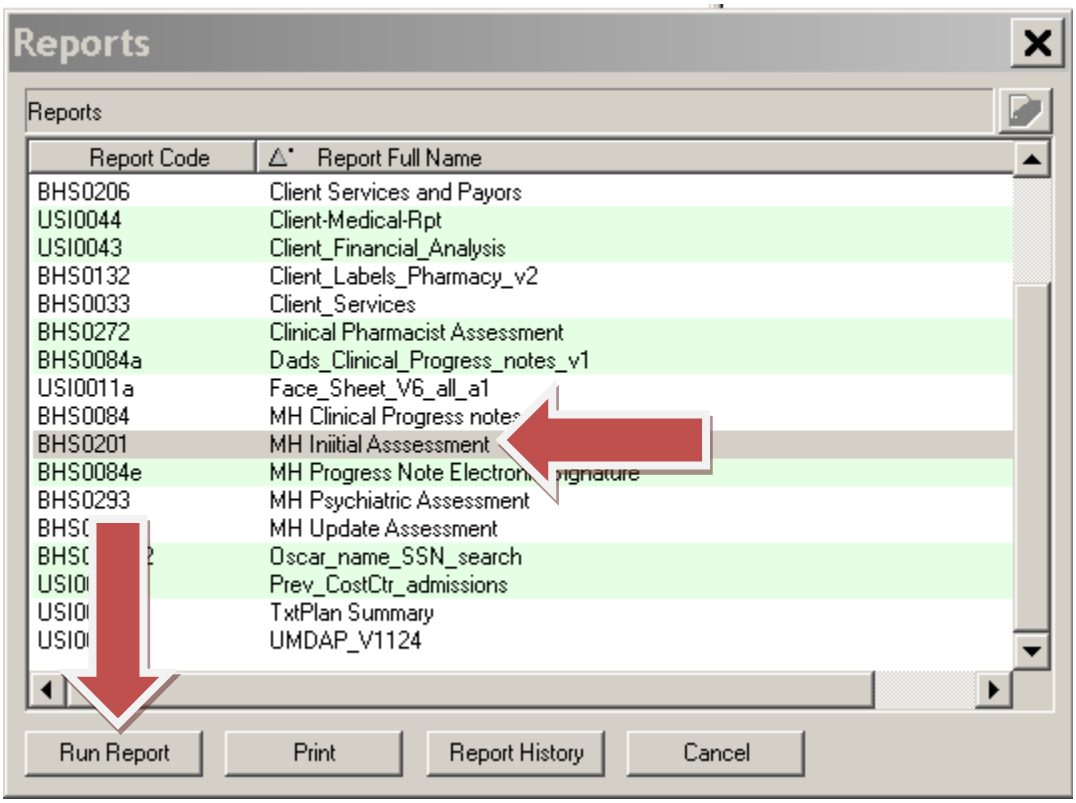


PRINTING AN INITIAL ASSESSMENT

To view or print an Initial Assessment, from the Navigator screen, right click on the **Profile of Client** button and choose **Reports**.



Choose **BHS0201, MH Initial Assessment** and click **Run Report**.

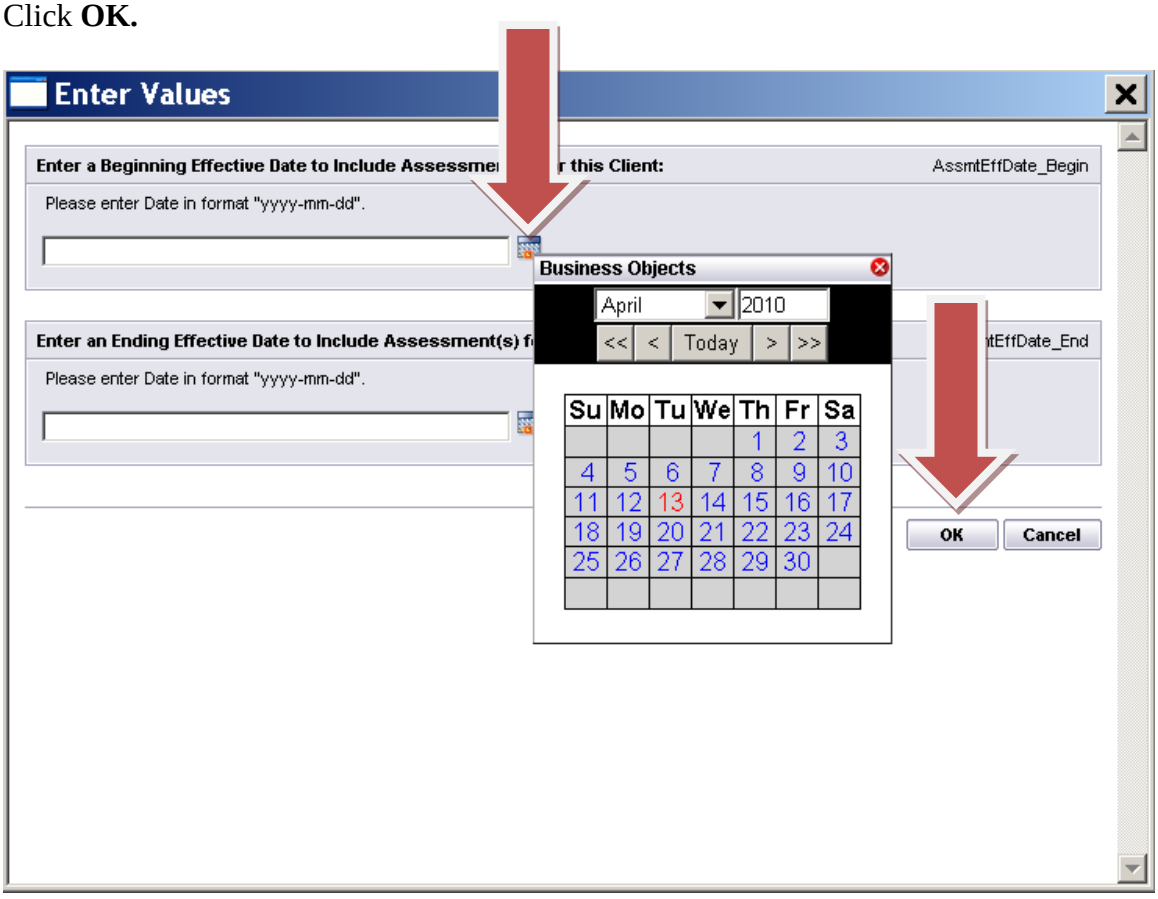


Enter a **Beginning Effective Date**: It is easiest to use the calendar to choose your Effective Date. Remember to use the Effective Date that you decided on when you were saving your assessment.

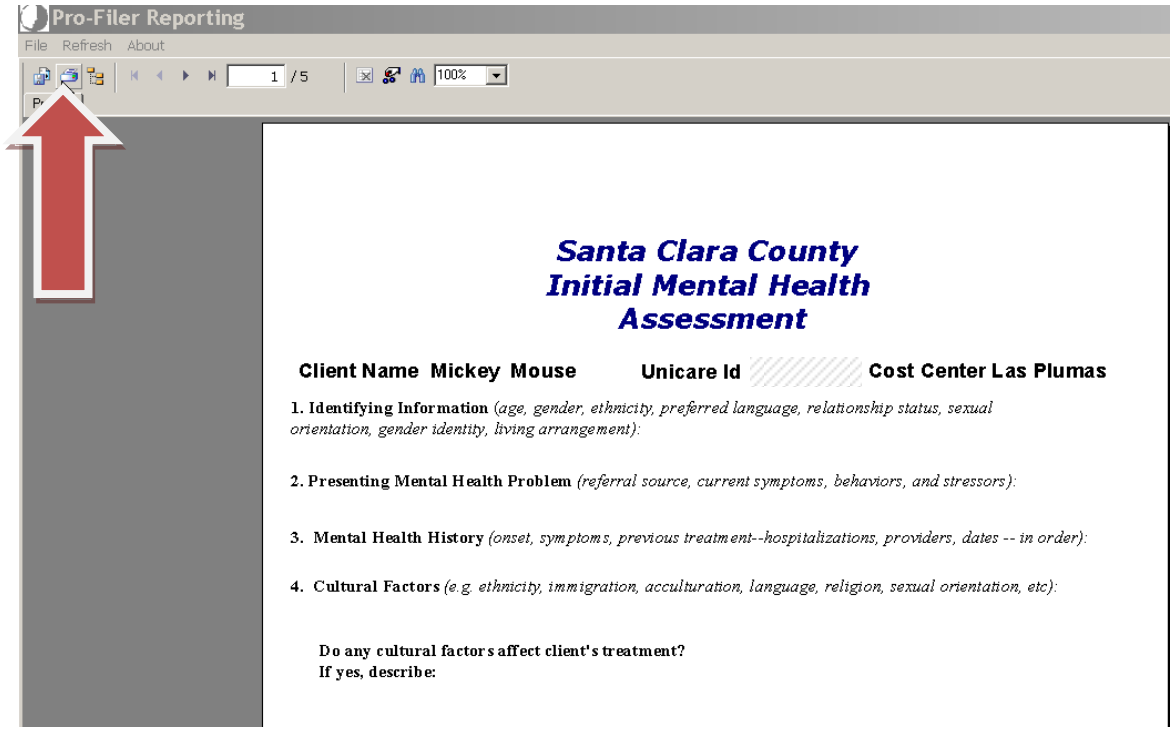
Enter an **Ending Effective Date**: Again, use the calendar.

You can enter a range of dates if you do not know the exact Effective Date.

Click **OK.**



Click the **Printer** icon. Please review your assessment to make sure it printed properly. Sign your assessment and place it in the chart.

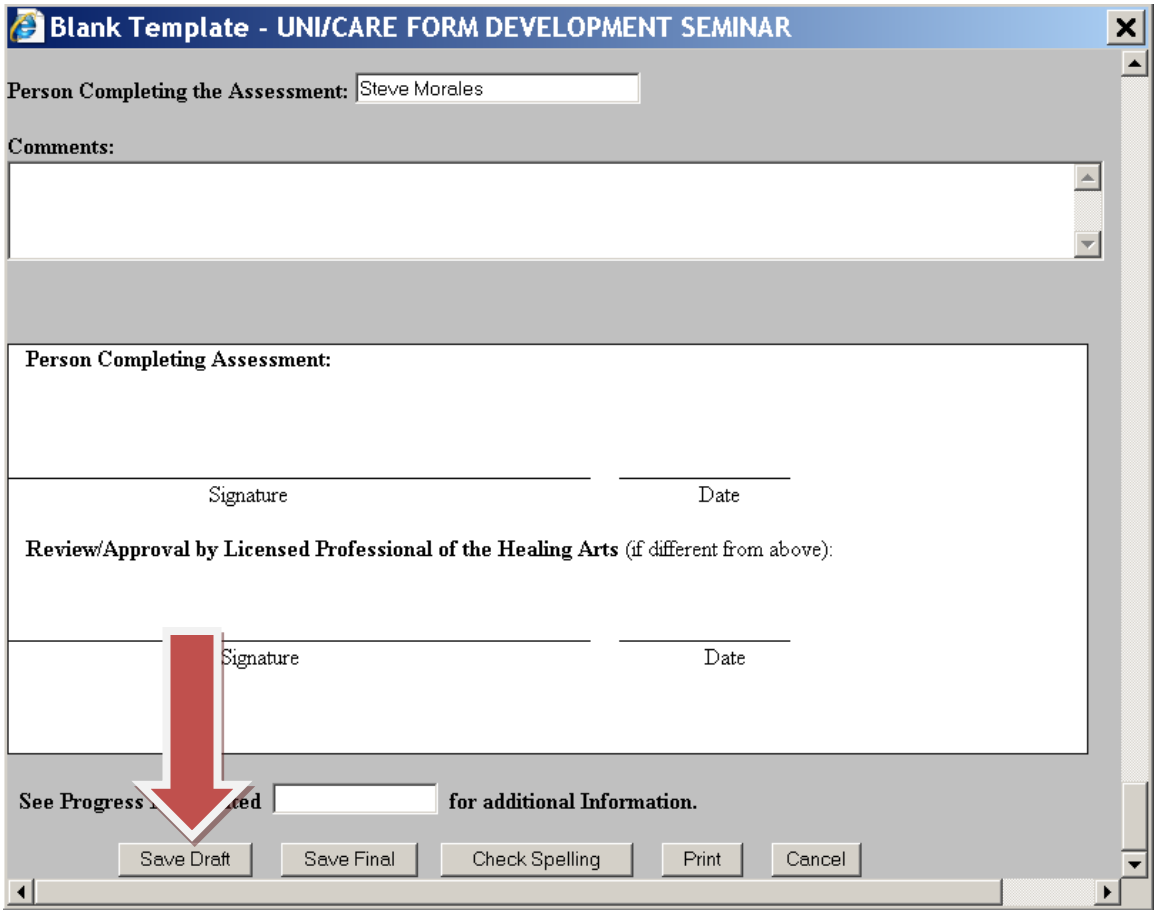

Pro-Filer Reporting
File Refresh About
1 / 5
100%
Santa Clara County
Initial Mental Health
Assessment
Client Name Mickey Mouse
Unicare Id
Cost Center Las Plumas
1. Identifying Information (age, gender, ethnicity, preferred language, relationship status, sexual orientation, gender identity, living arrangement):
2. Presenting Mental Health Problem (referral source, current symptoms, behaviors, and stressors):
3. Mental Health History (onset, symptoms, previous treatment--hospitalizations, providers, dates -- in order):
4. Cultural Factors (e.g. ethnicity, immigration, acculturation, language, religion, sexual orientation, etc):
Do any cultural factors affect client's treatment?
If yes, describe:

SAVING A PARTIAL INITIAL ASSESSMENT

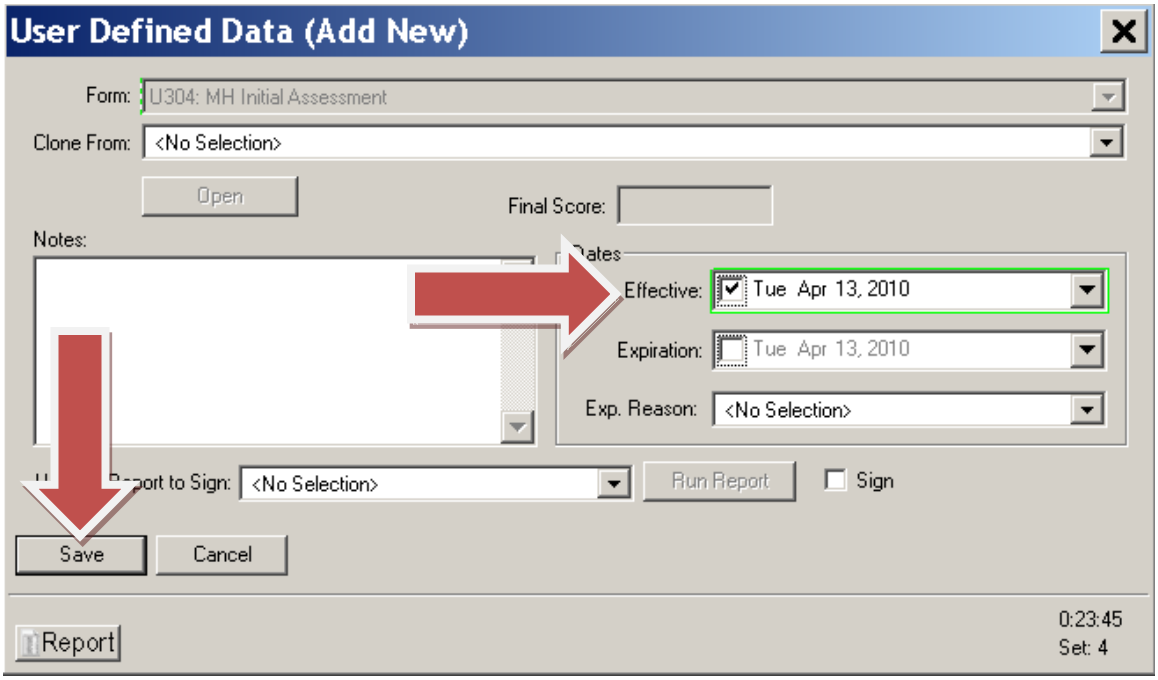
You have the ability to save a partial assessment. This is called a Draft.

When you are ready to exit the form, click the **Save Draft** button at the bottom of the form.

You are able to save as many drafts as you need to.

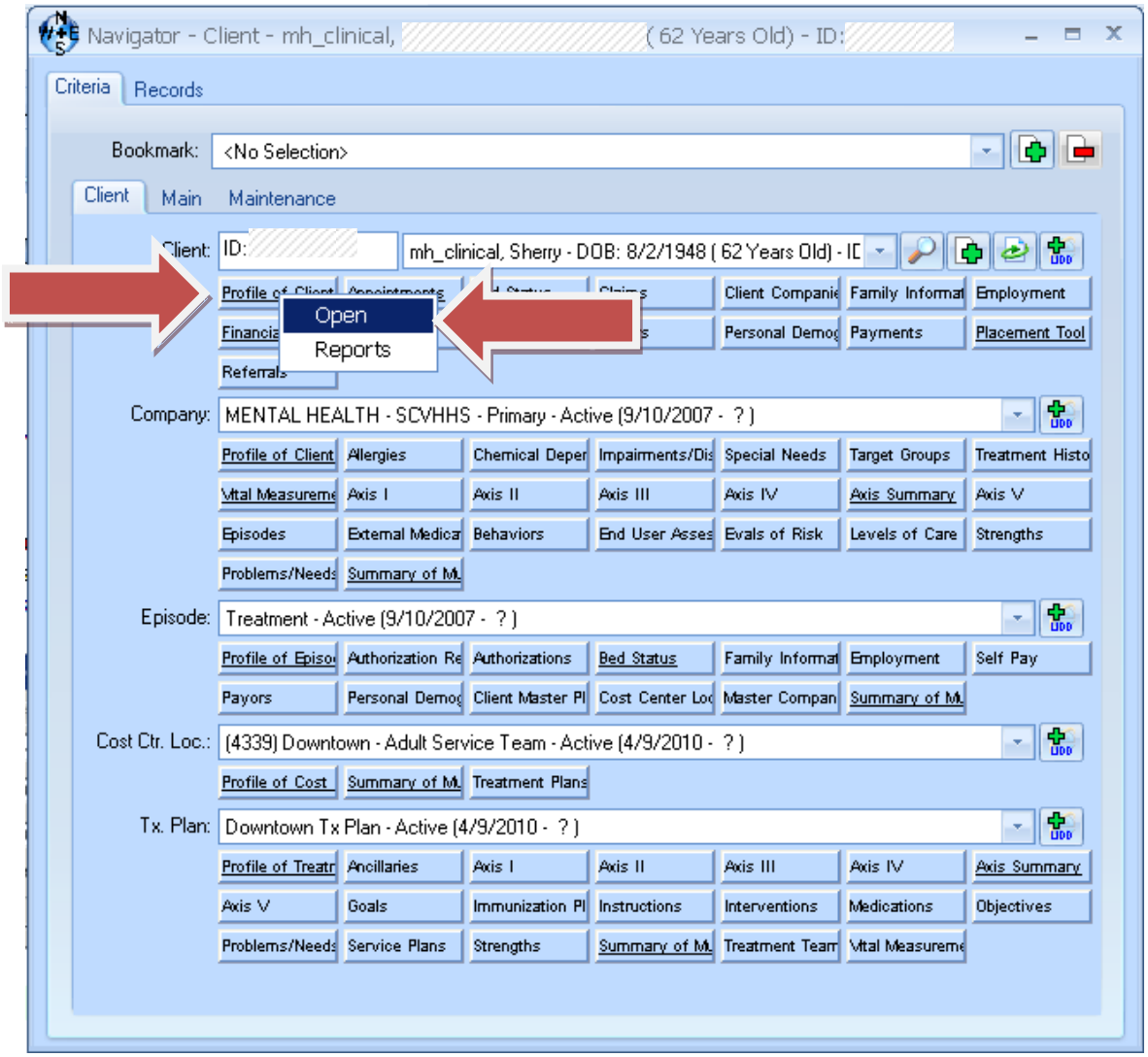


Click the **Effective** box and then **Save**. Remember to adjust the Effective Date if needed.

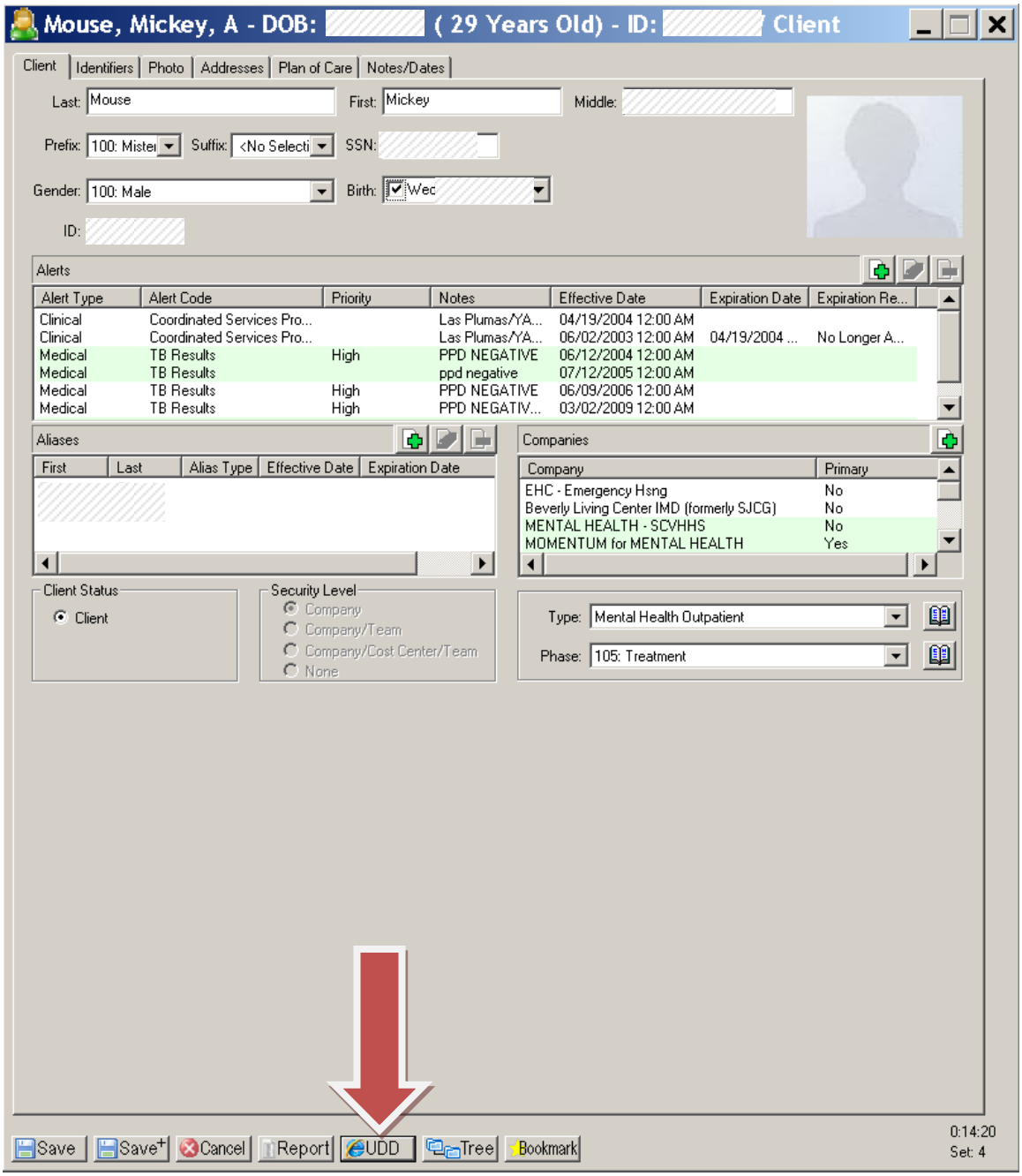


RETRIEVING A PARTIAL OR COMPLETED INITIAL ASSESSMENT

When you are ready to return to your assessment draft or you want to view a completed Initial Assessment, from the Navigator screen, right-click on the **Profile of Client** button and choose **Open**.

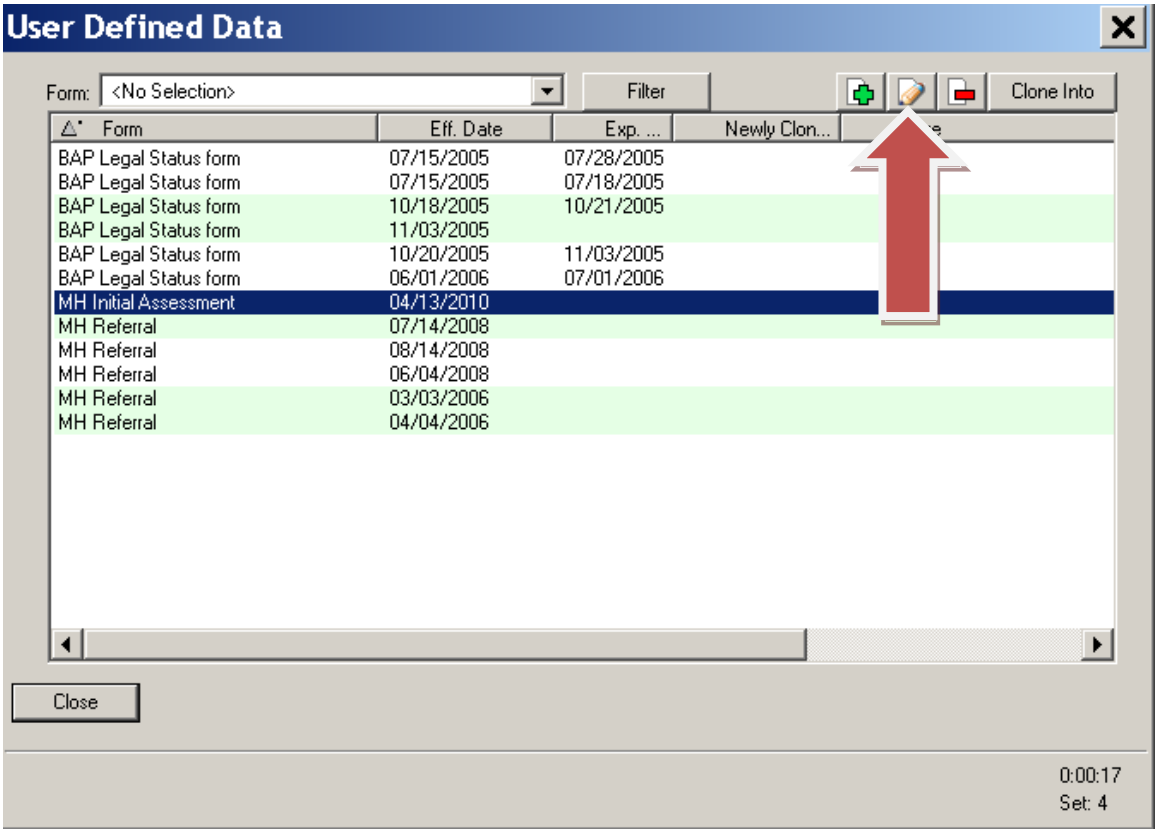

Navigator - Client - mh_clinical, (62 Years Old) - ID:
Criteria
Records
Bookmark:
<No Selection>
Client
Main
Maintenance
Client:
ID:
mh_clinical, Sherry - DOB: 8/2/1948 (62 Years Old) - ID
Open
Reports
Company:
MENTAL HEALTH - SCVHHS - Primary - Active (9/10/2007 - ?)
Episode:
Treatment - Active (9/10/2007 - ?)
Cost Ctr. Loc.:
(4339) Downtown - Adult Service Team - Active (4/9/2010 - ?)
Tx. Plan:
Downtown Tx Plan - Active (4/9/2010 - ?)

Click on the **UDD** button.



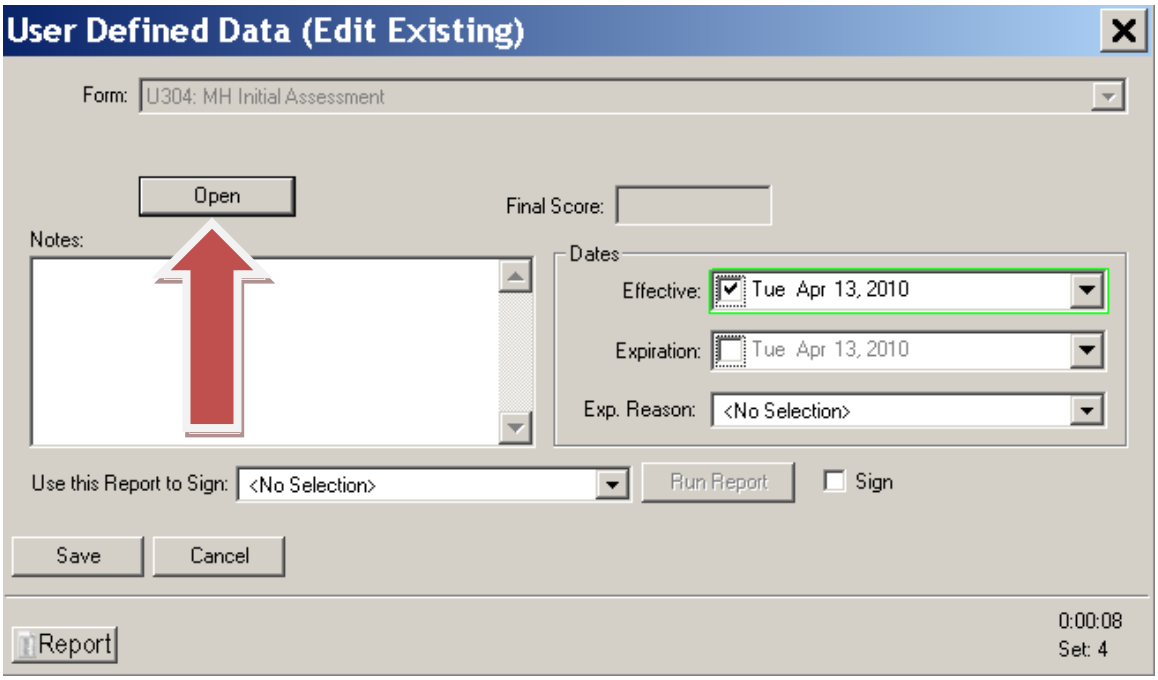
The UDD screen will appear with the Initial Assessment listed in the Form field.

Double-click on it or single click on it and then click the **Edit icon** (yellow pencil).



Click on the **Open** button and the Initial Assessment form will open up and you will be able to continue with your draft or just view the assessment.

If you are opening a Final Initial Assessment, you will see this message – "This form has been saved as FINAL – no changes will be allowed". Click **OK**.



RECORDING AN UPDATE ASSESSMENT

The process for accessing, recording and printing an Update Assessment is exactly the same as for an Initial Assessment. However, the form and the report numbers are different.

1. To pull up your Update Assessment, choose **B305, MH Update Assessment** from the User Defined Data (UDD) screen.

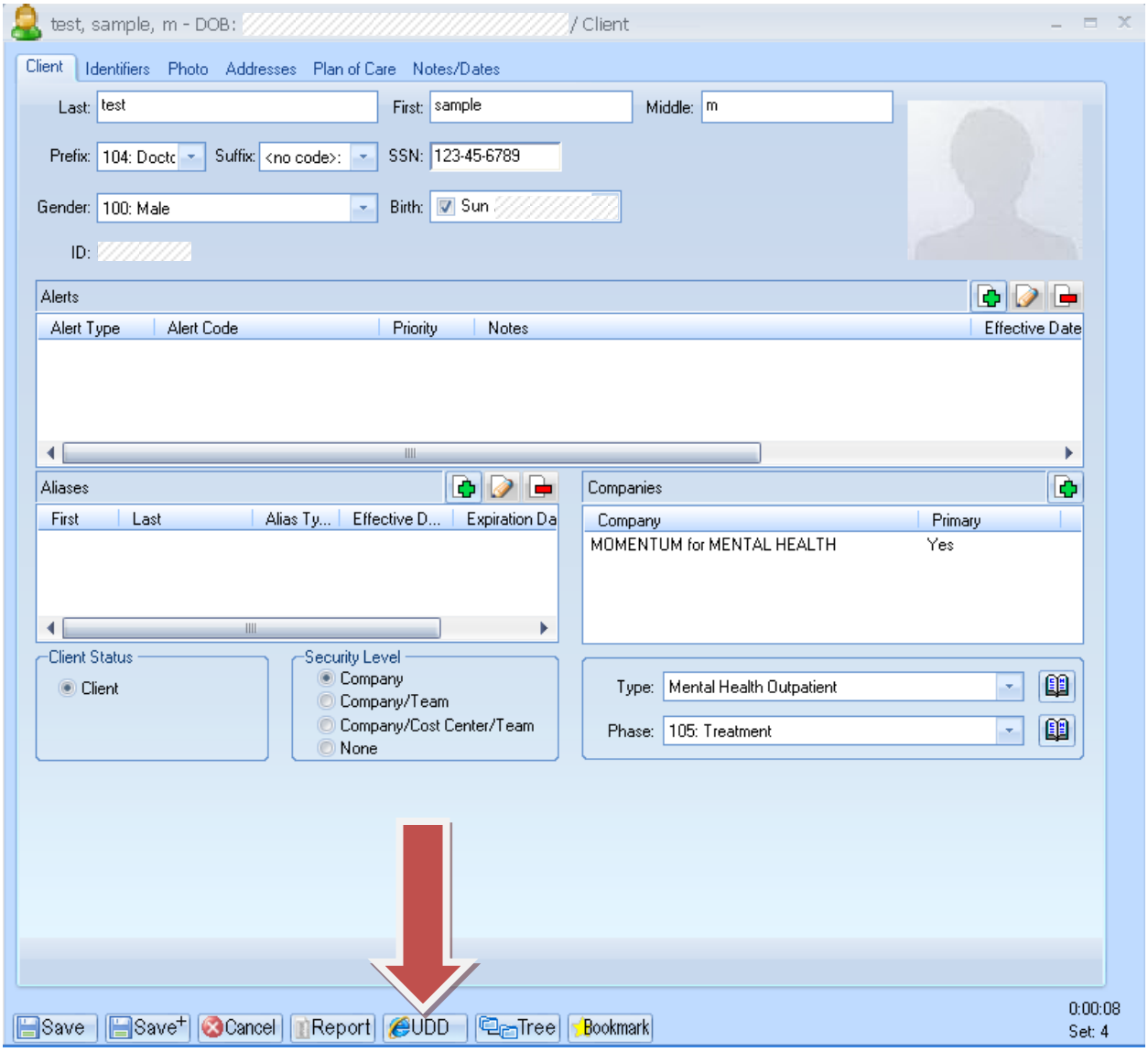
2. To print your Update Assessment, choose **BHS0277, MH Update Assessment** from the Reports screen.

RECORDING A TRANSFER ASSESSMENT

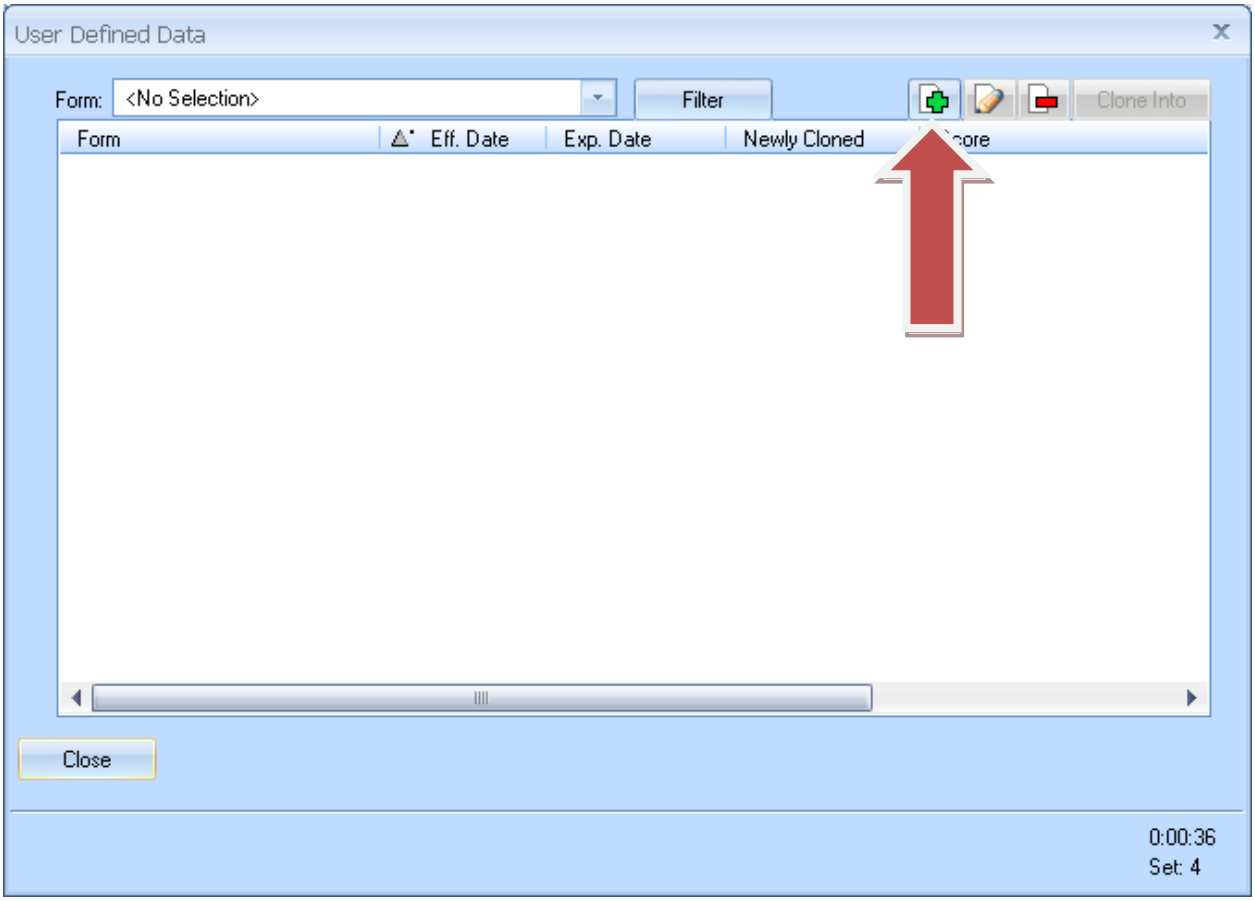
The following instructions are for recording the signature date of an assessment that is being transferred to a new program. A report will track when the next Update Assessment is due.

Note: If a client is transferred to another provider at another program (cost center), that new provider can accept the assessment if it was completed within one year and the new provider agrees with the assessment data and diagnosis.

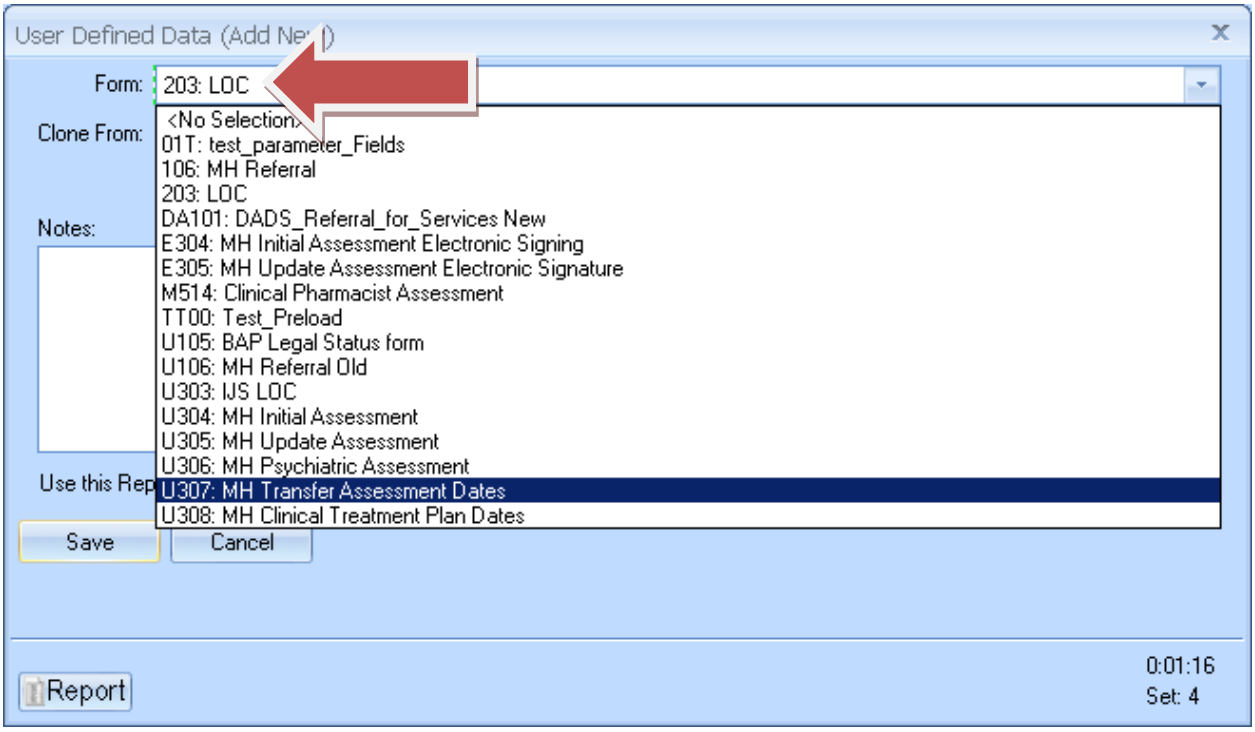
Choose a client and open the Profile of Client. Click the **UDD** button.



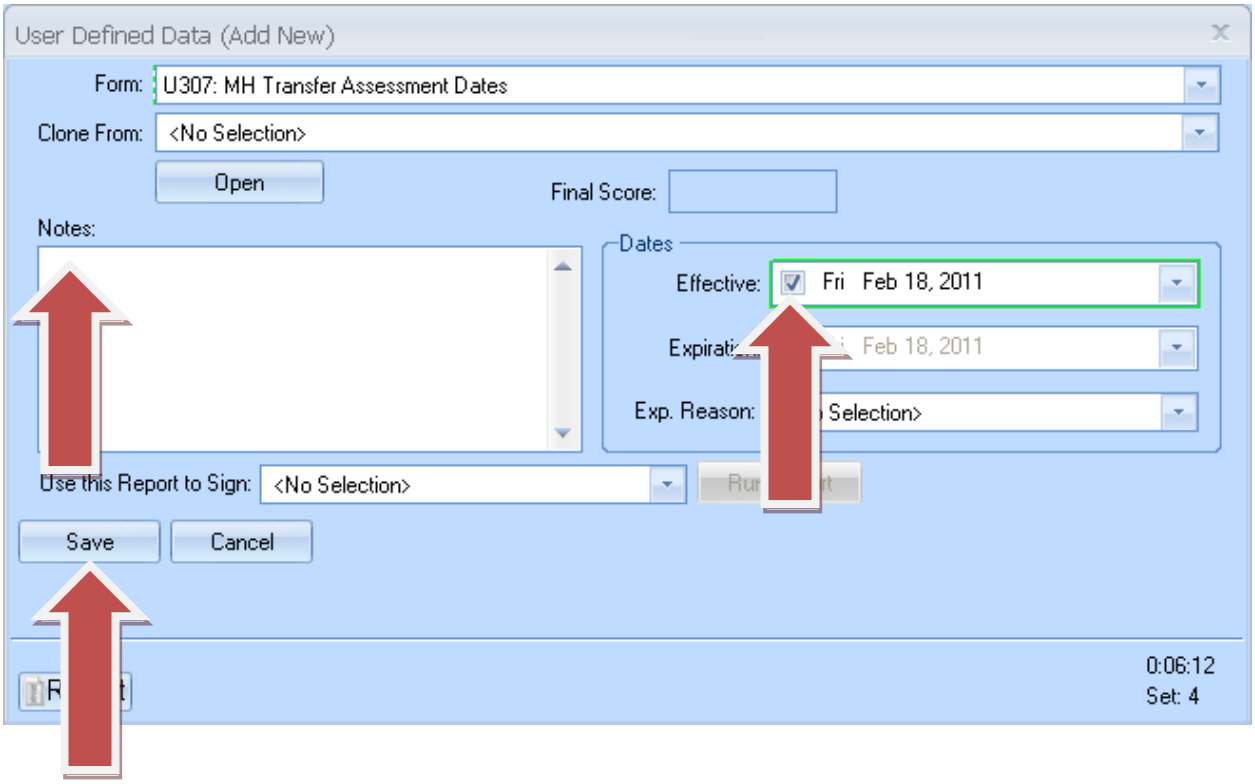
Click on the **Add New** icon (green plus sign).



Click on the Form dropdown and choose **U307: MH Transfer Assessment Dates**.

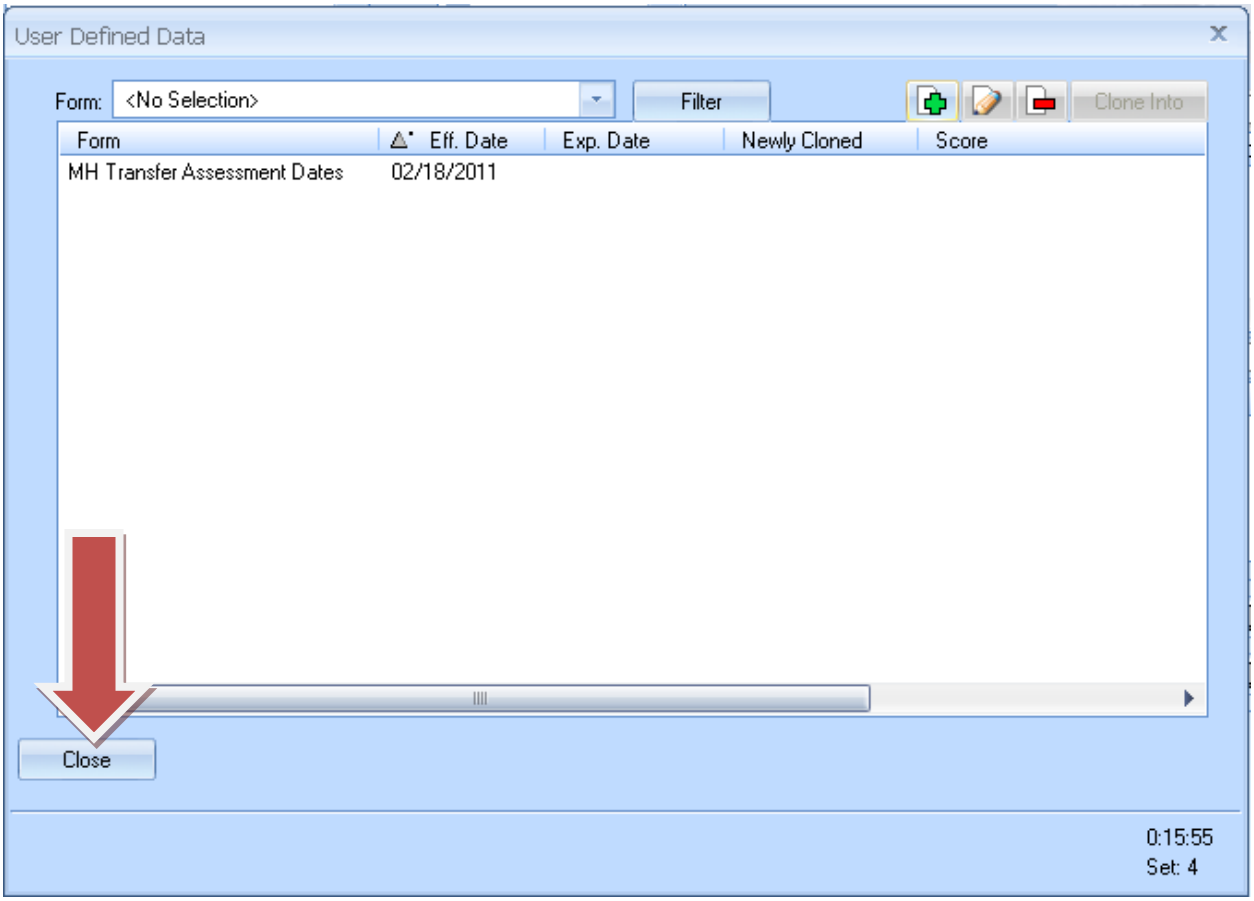


1. Click the Effective Date box. **This is very important. Change the date to match the signature date on the Transfer Assessment, not the date you are accepting the assessment.**
2. Enter a note stating where the Transfer Assessment came from and on what date you accepted it on.
3. Click the **Save** button.



Your Form and Effective Date are noted. **Double check that the Effective Date is the same date as on the Transfer Assessment.**

Click the **Close** button.



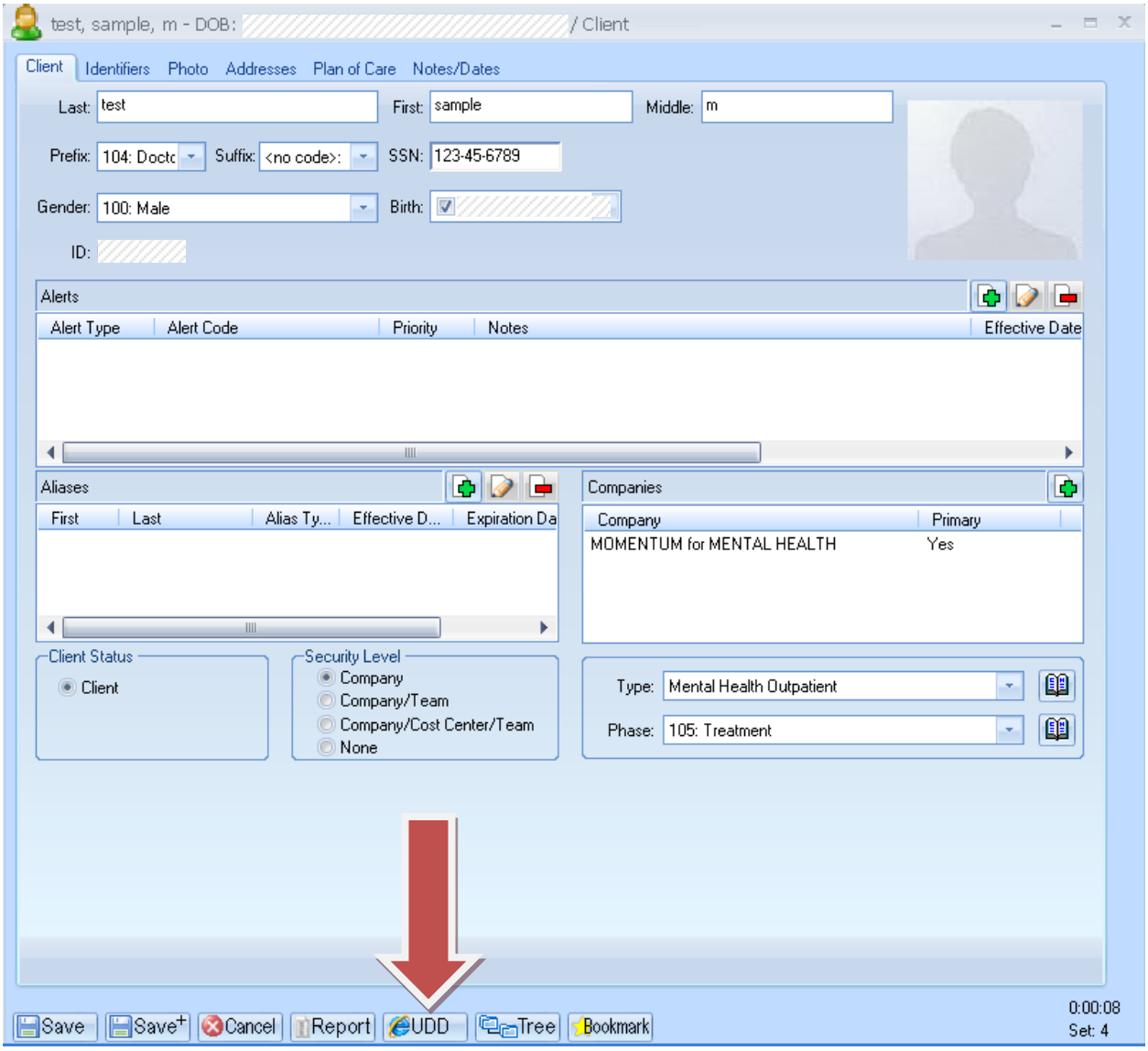
You can now record a Plan Development service, write a progress note and record an EBP/SS. Please enter all Transfer Assessments for all of your clients in this manner so that your report will be complete.

RECORDING A CLINICAL TREATMENT PLAN

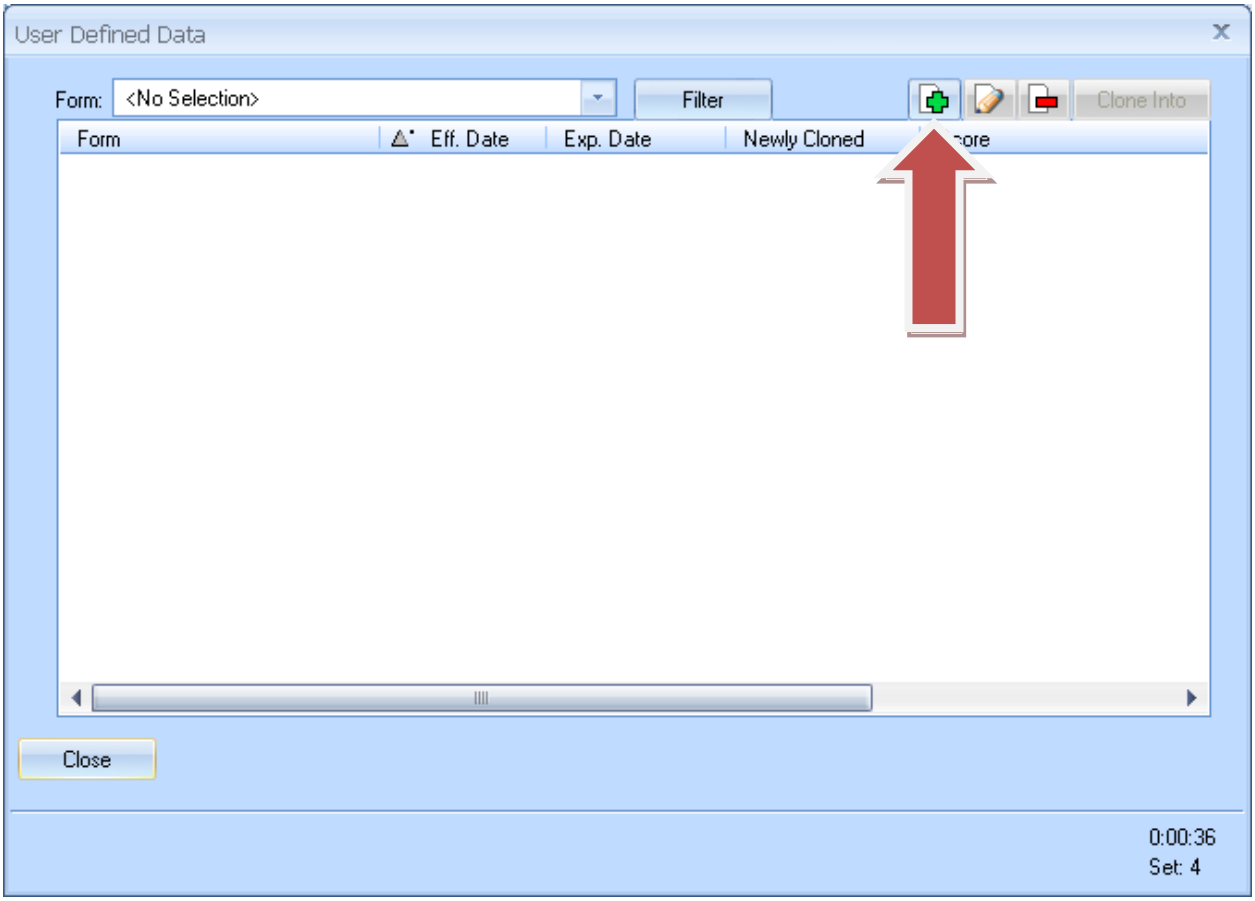
The following instructions are for recording a Start Date for a Clinical Treatment Plan. A report will identify when the next Treatment Plan is due 30 days prior to its annual due date.

Choose a client and open the Profile of Client screen.

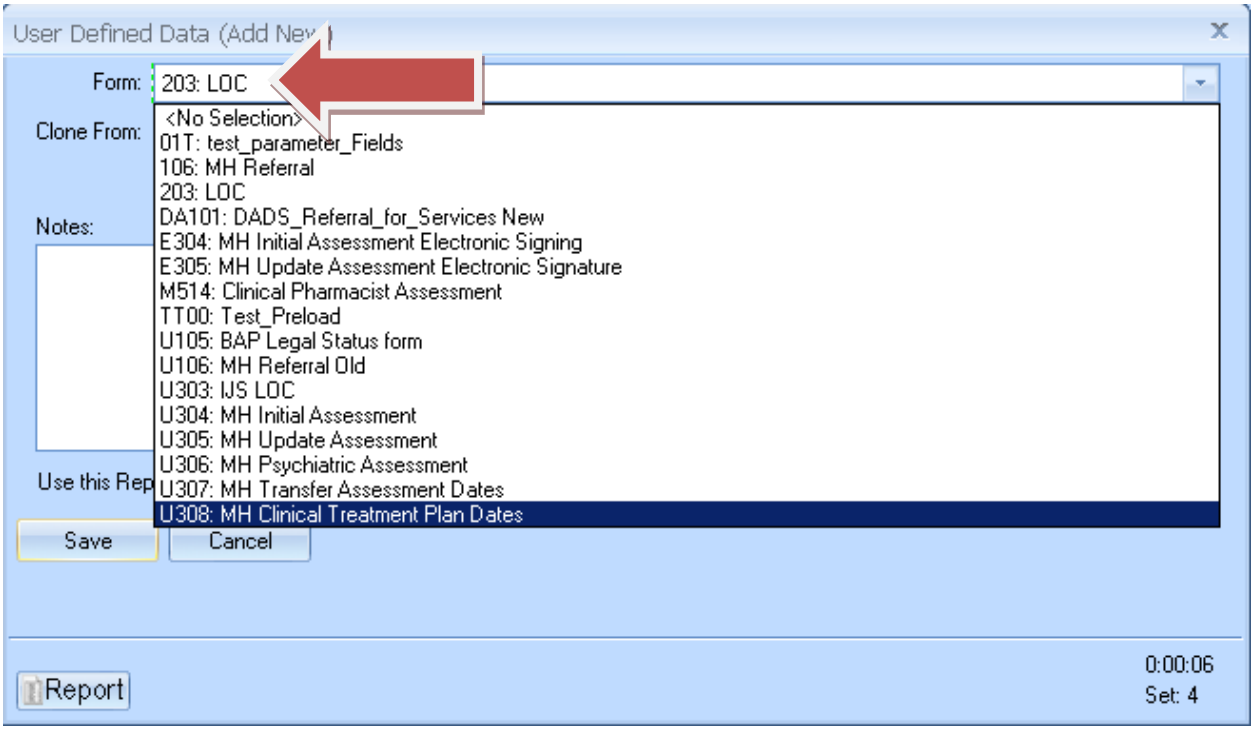
Click the **UDD** button at the bottom of the screen.



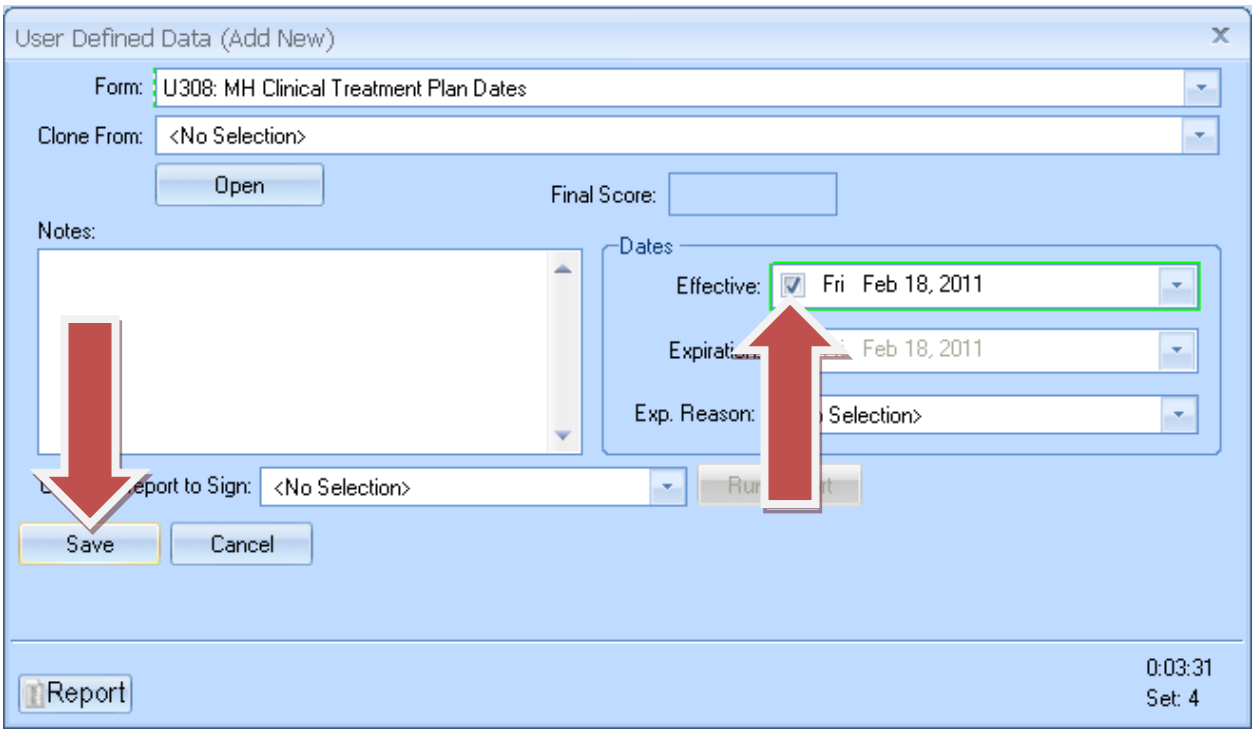
Click on the **Add New** icon (green plus sign).



Click on the Form dropdown and choose **U308: MH Clinical Treatment Plan Dates**.

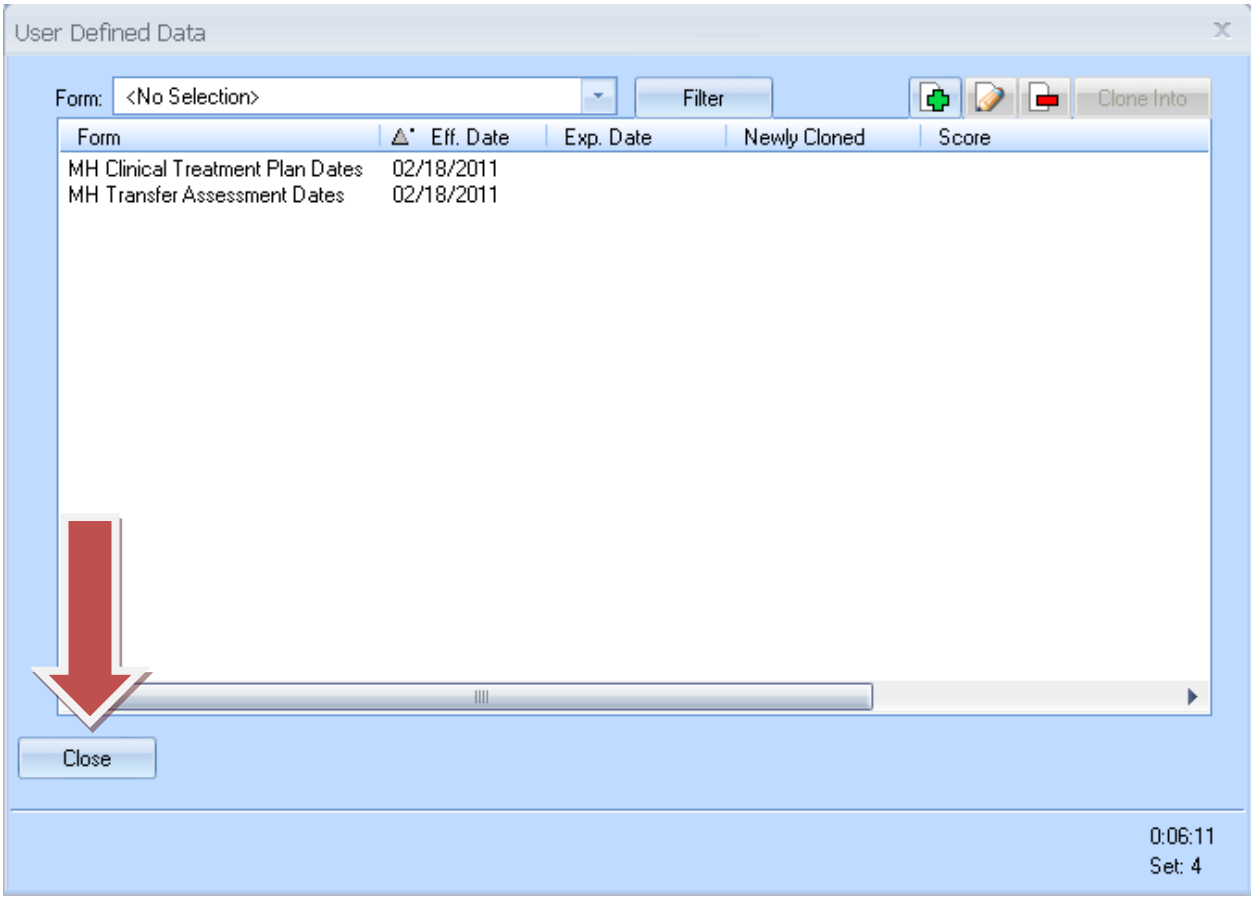


1. Click the Effective Date box. **This is very important. Change the date to match the Start Date on the Treatment Plan.** The Effective Date can be changed to past or future dates as needed.
2. Click the **Save** button.



Your Form and Effective Date are noted. **Double check that the Effective Date is the same date as the Start Date on your Treatment Plan.**

Click the **Close** button.



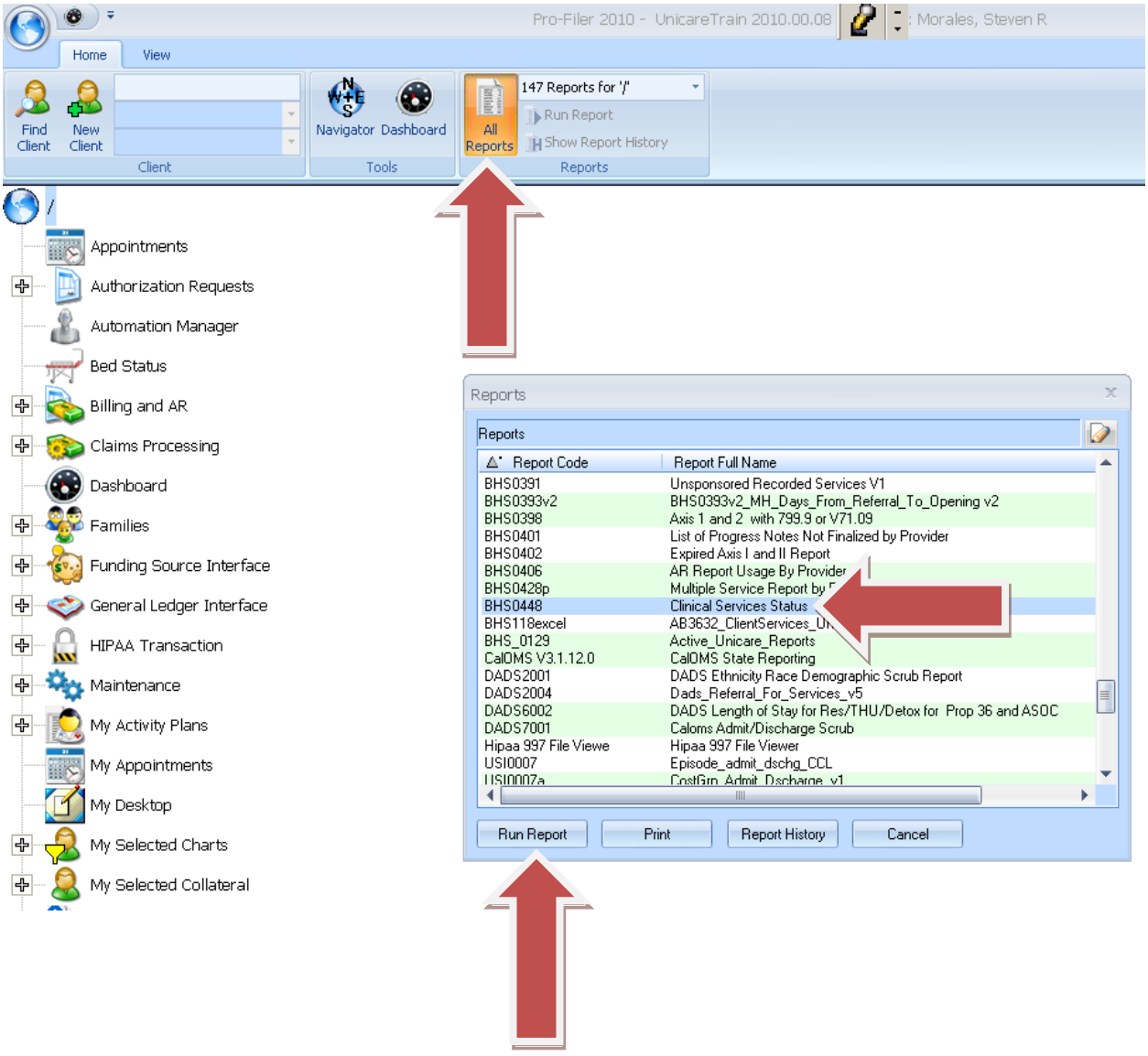
If you haven't done so, you can now record a Plan Development service, write a progress note and record an EBP/SS.

Please enter all Treatment Plan Start Dates for all of your clients so that your report will be complete.

CLINICAL SERVICES STATUS REPORT

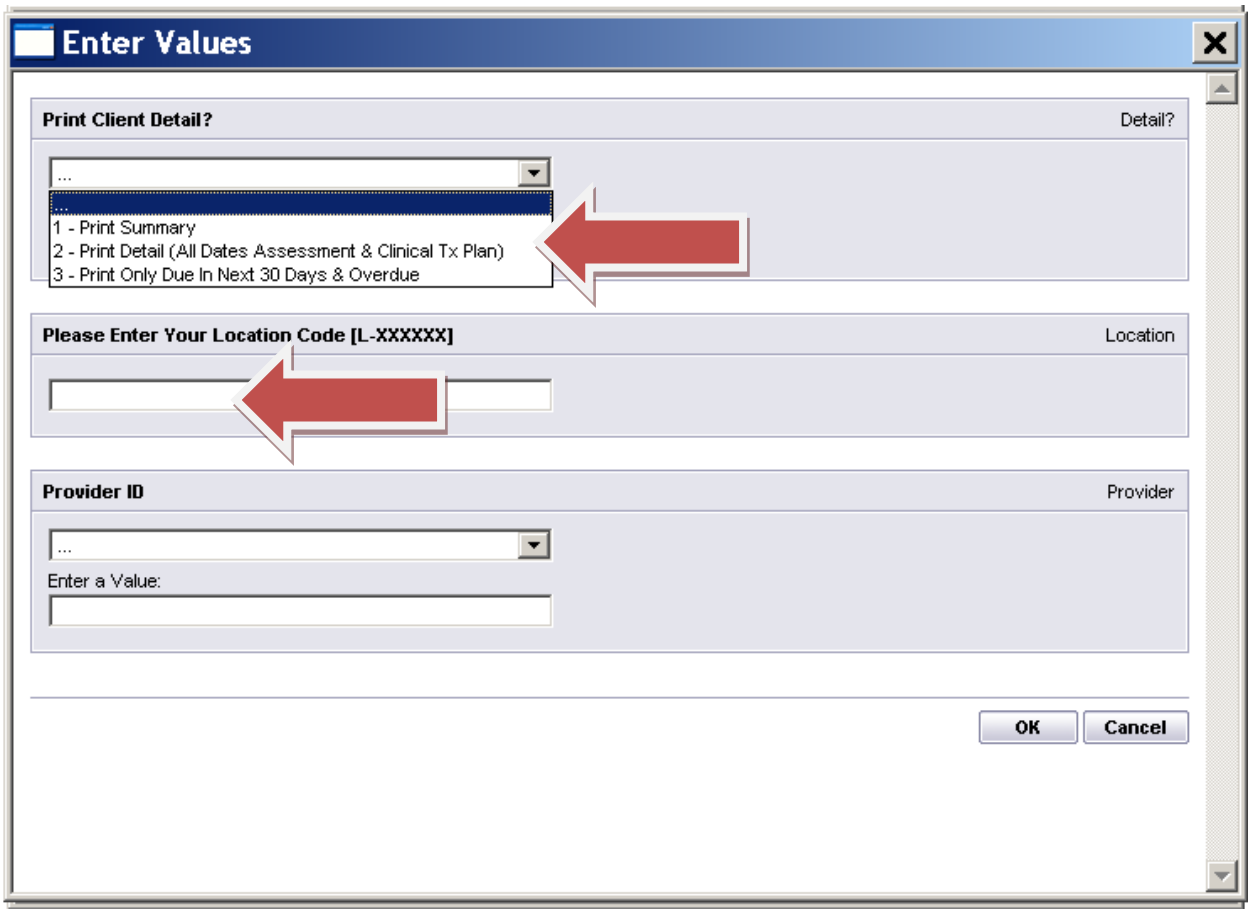
The tickler report is called Clinical Services Status.

At the Tree View, click on **All Reports**, then choose **BHS0448** and then click on **Run Report**.



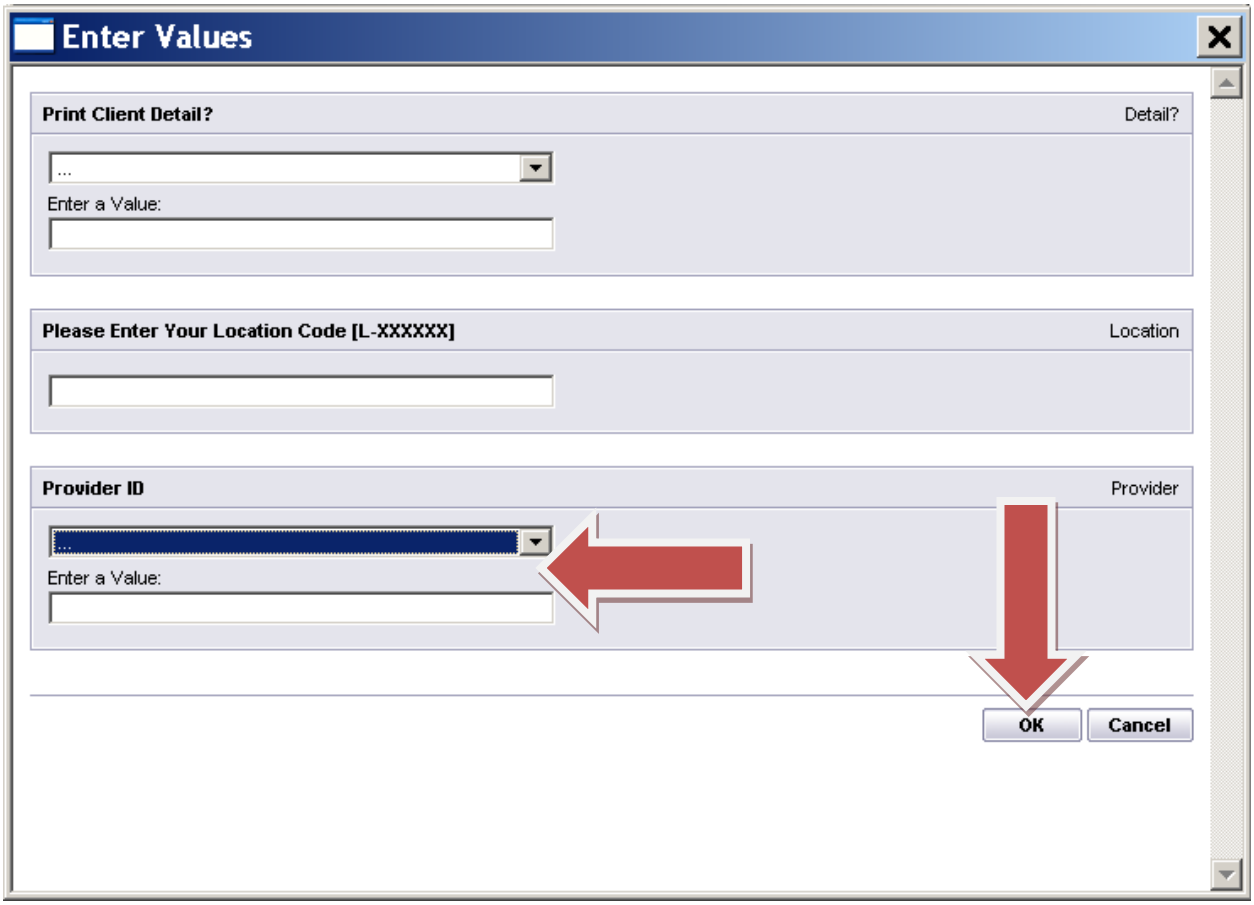
Make your choice for client detail.

Enter your **Location Code**. If you don't know your Location Code, this can found in the Who Am I report.



For Provider ID, enter your Unicare Provider ID in the Enter a Value field or choose All from the dropdown menu.

Click **OK** and your report will appear.



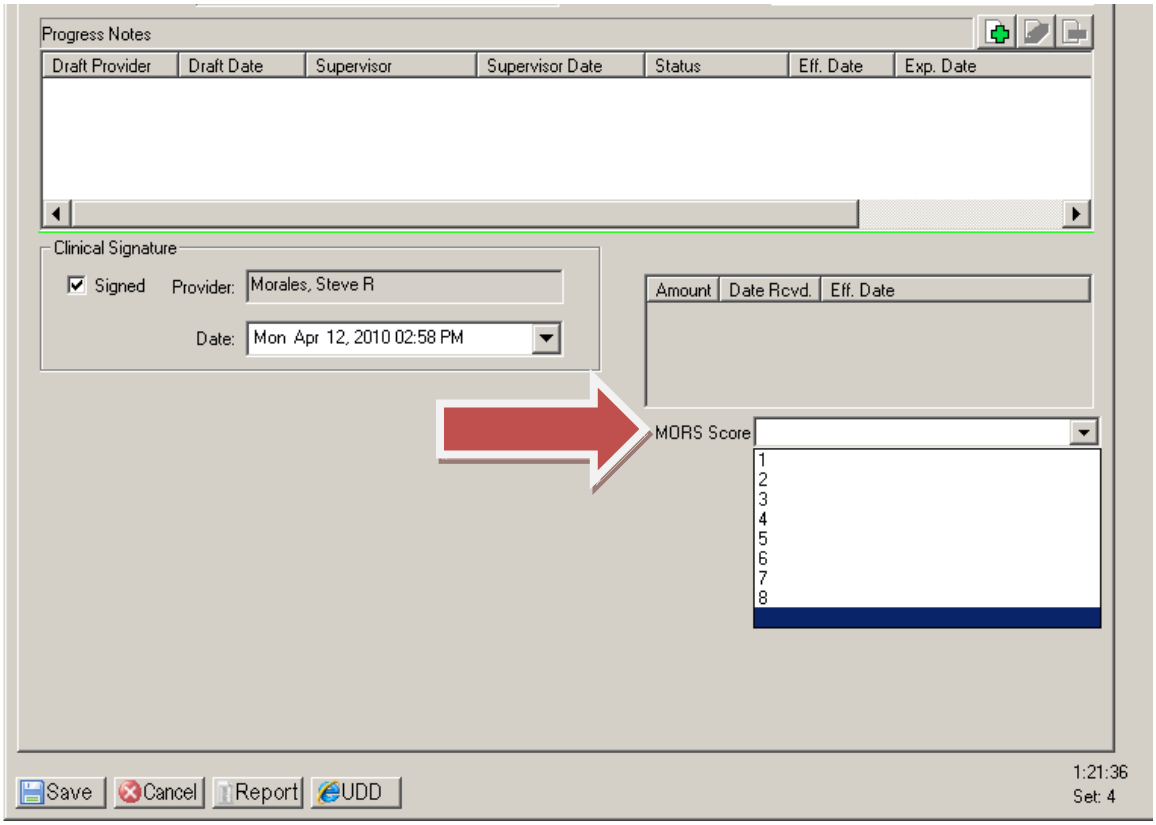
RECORDING MORS

The Milestones of Recovery Scale (**MORS**) is to be filled out by providers working in the Adult System of Care (Adult, Older Adult divisions and FQHC clients if opened in Unicare for Case Management services.)

Note: Adult Residential, Crisis Residential and Day Rehabilitation programs are not required to provide MORS at this time.

The scoring field is on the Recorded Service screen, at the bottom right-hand corner. Include the time it takes to administer the **MORS** to whatever Mental Health service you provided that day to that client. You can include a sentence like "MORS score of ___." to your progress note.

MORS is to be scored every 30 days for FSP clients and every 90 days for non-FSP clients.



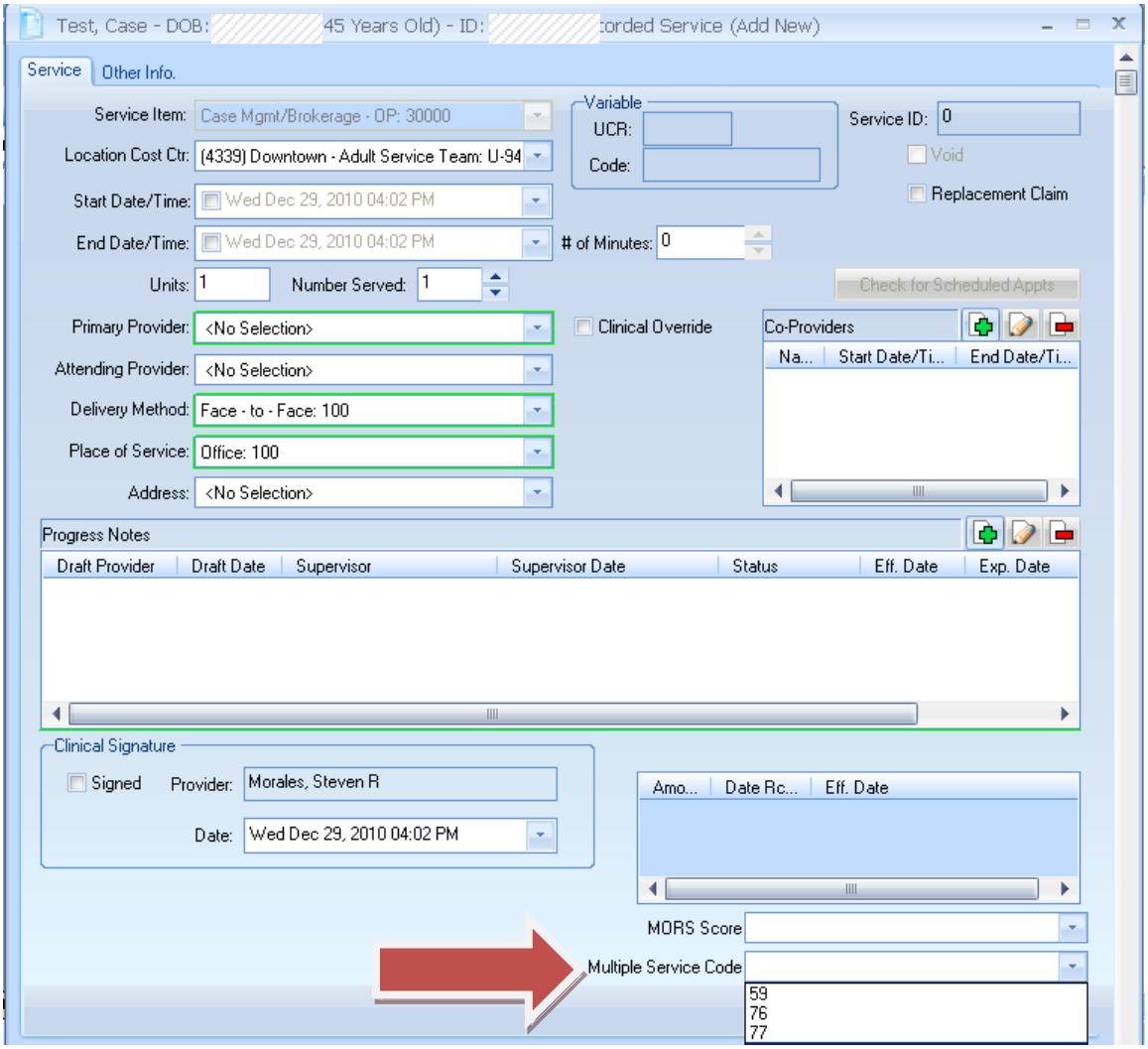
RECORDING A MULTIPLE SERVICE CODE

A Multiple Service Code is to be entered by providers when you record two identical services on the same day to the same client for the same amount of time. There is only one situation when a Multiple Service Code will be required and this will not occur very often. Multiple Service Codes are recorded on the Recorded Service screen. Record a 76 on both of these services. You do not need to use 59 or 77 for any reason on any service.

Example #1: if you provided two Case Management (CM) services for the same client on the same day for 30 minutes each, you would record a 76 on both of these CM services.

Example #2: if you provided two Plan Development services for the same client on the same day but one service was for 60 minutes and the other service was for 20 minutes, you would not need to enter a Multiple Service Code for either service.

Note: Activity, Institutions and IMD and FSP Linkage do not need a Multiple Service Code.

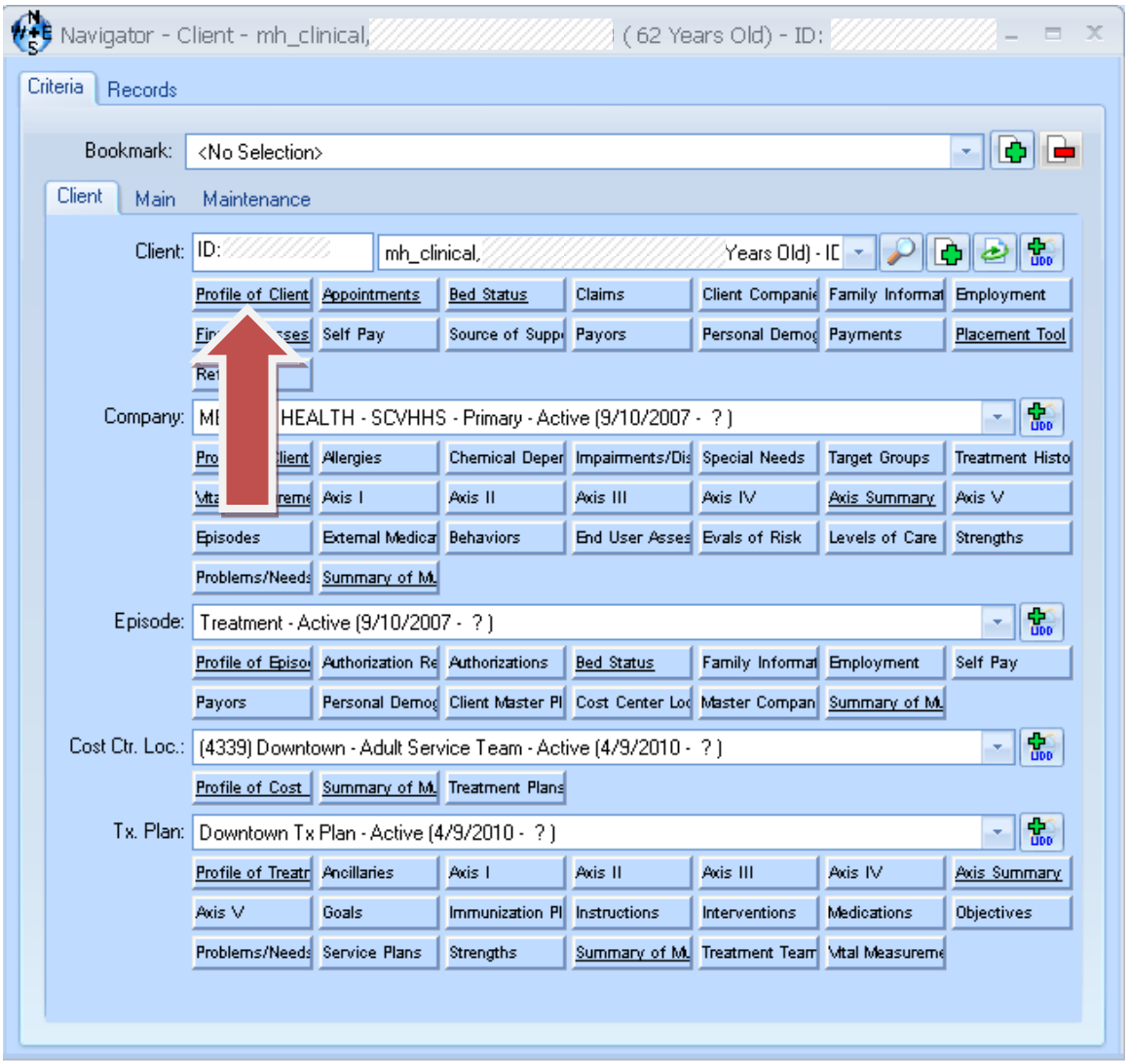


VOIDING A SERVICE

Mistakes happen. Recording an incorrect date or amount of time in the Service Recording screen or making an error in a progress note or even writing a progress note on an incorrect client are all possibilities.

If this occurs, the clinician should void the service by following these procedures.

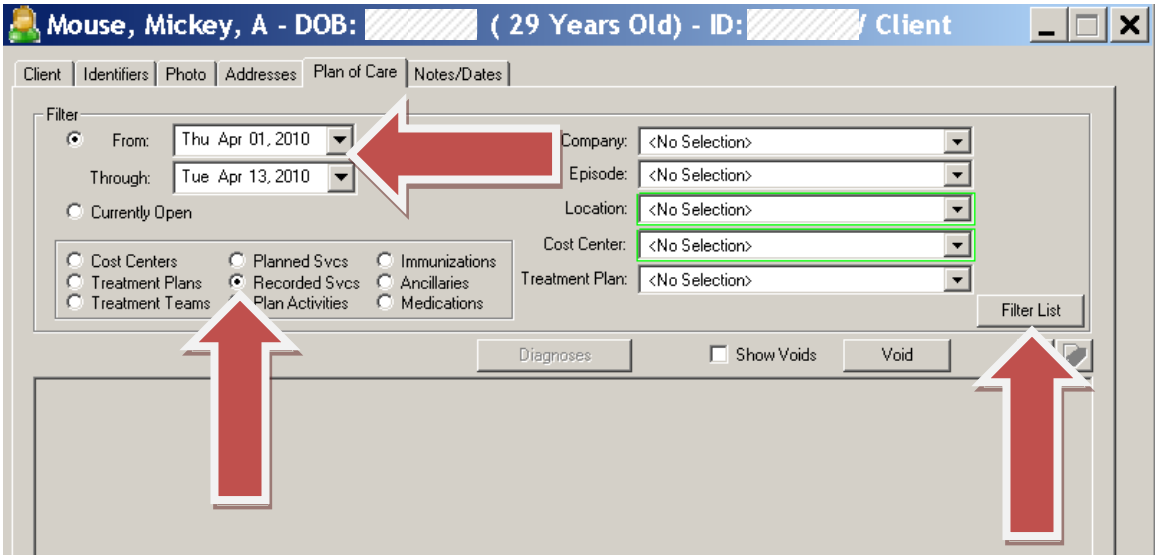
From the Navigator screen, find your client and then click the **Profile of Client** button.



Retrieving a recorded service:

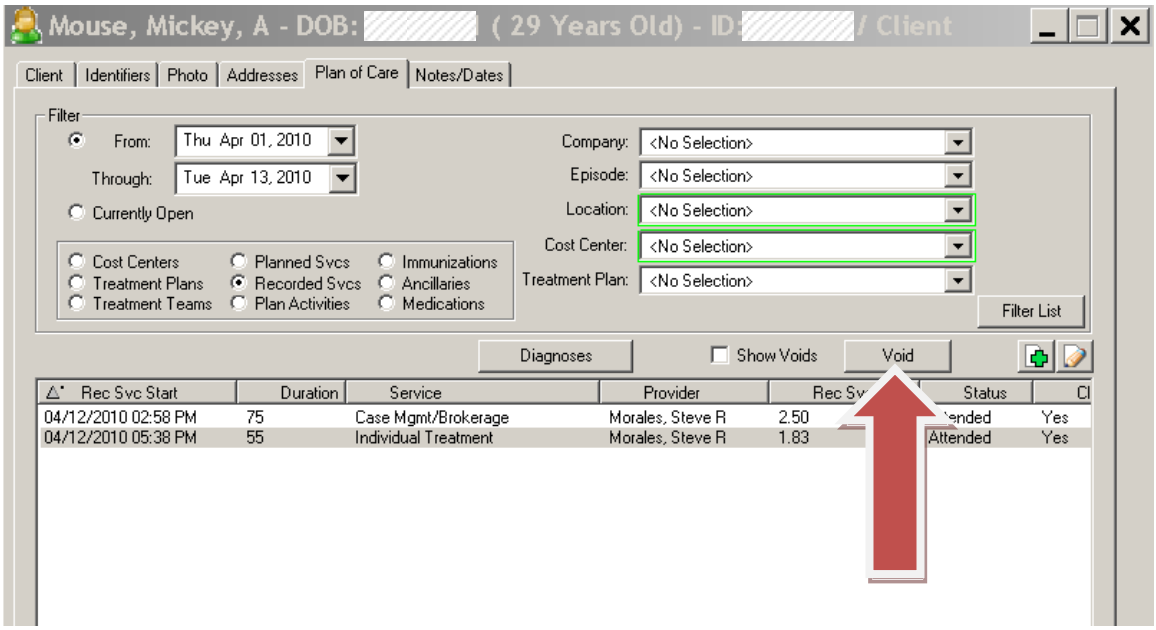
1. If necessary, change the Filter dates fields to include the date of the service you are searching for. If you do change these dates, don't forget to click the radio button to the left of From.
2. Click **Recorded Svcs**.
3. Click **Filter List**.

Note: Never expire a progress note.



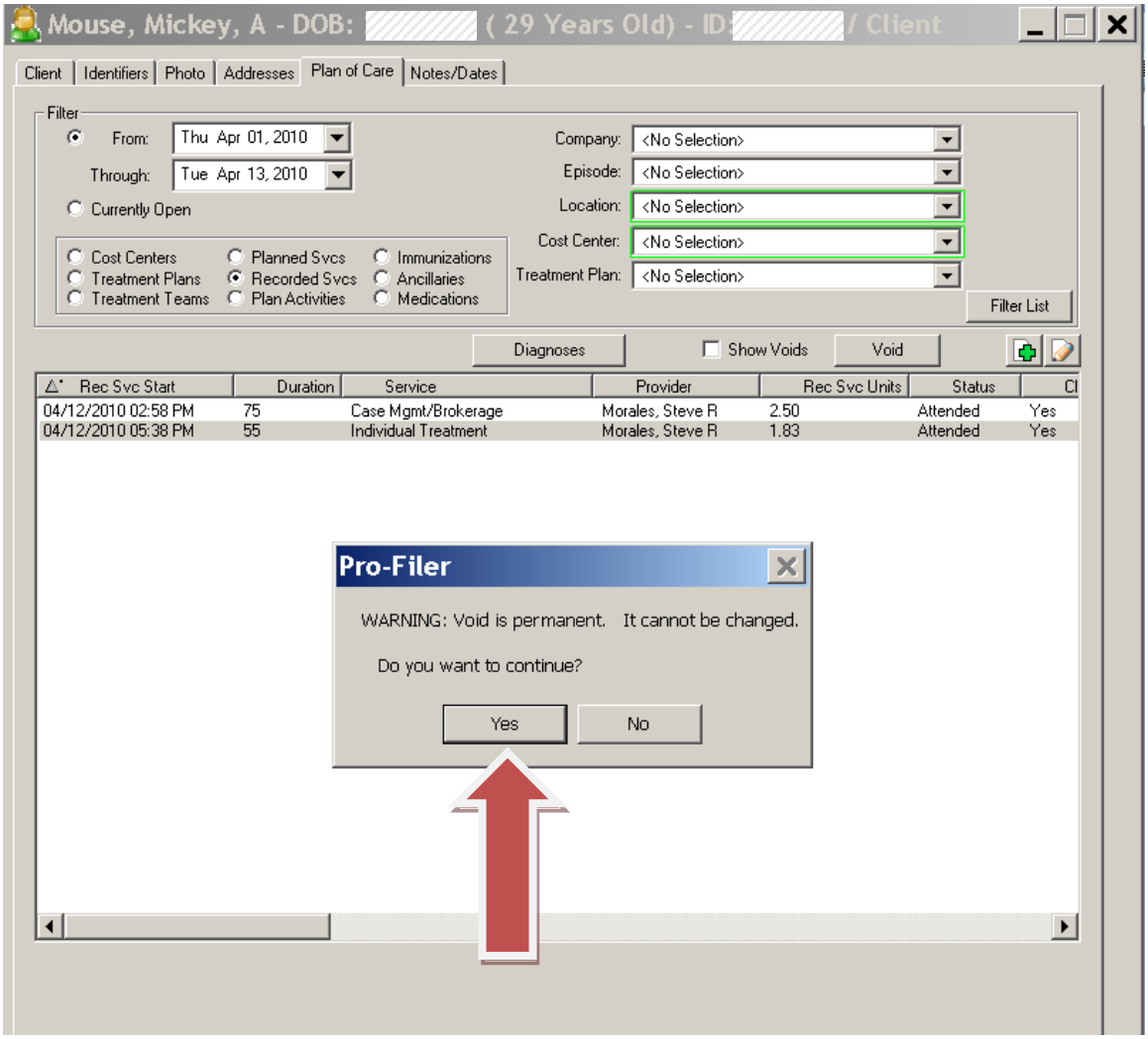
1. Highlight the service you want to void.
2. Click **Void**.

Note: If the service that you want to void has Yes under the Billing Signed column, then you must contact your clerical support and IS to void this service.



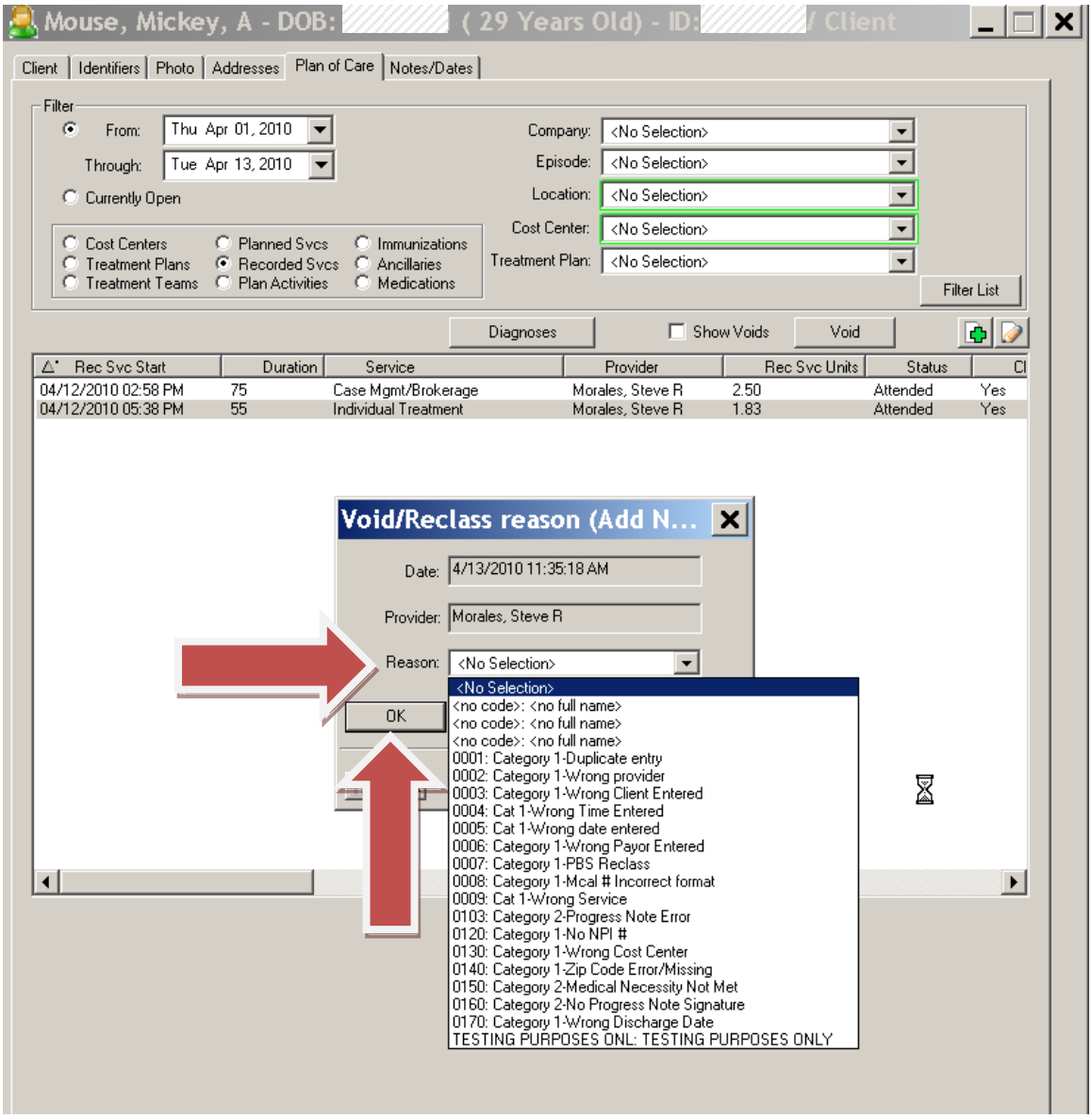
The following screen will be displayed.

You will receive a Warning box. Click **Yes**.



The following screen will be displayed.

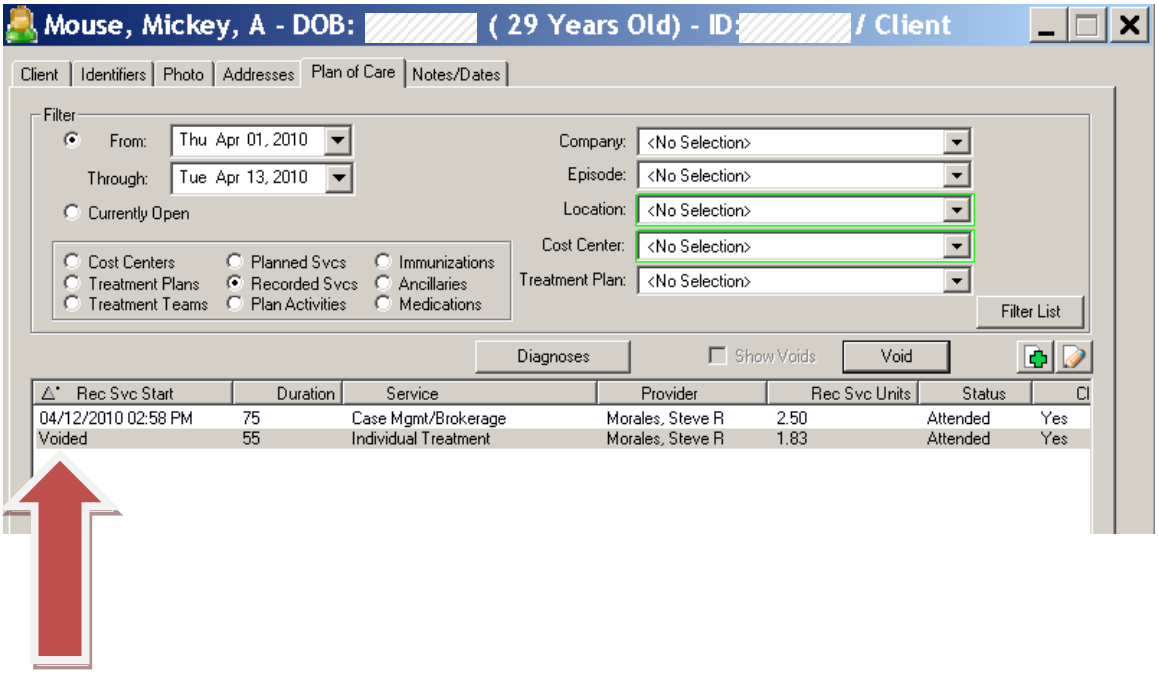
1. Click on the drop down menu and choose a **Reason** for the void.
2. Click **OK.**



The following screen will be displayed.

Your Recorded Service is now showing as Voided.

See Appendix E to review the County's Policies and Procedures section 635 on Service Item Voiding/Deletion – Unicare.



If you need to replace this voided service, now would be an ideal time. If the progress note is still good, you can go into it, copy it and then paste it into the replacement service.

COPYING AND PASTING A PROGRESS NOTE

Unicare allows you to copy a Unicare progress note and paste it onto another Unicare progress note screen. There are at least two instances when this could save you time.

1. Maybe a progress note that you wrote (but had to void for some reason) is still good for the corrected progress note or just needs some editing. You can copy and paste either before or after you void the service.
2. If you are writing group notes for multiple clients, you could copy and paste the first sentence (which describes the group, how many clients and clinicians participated and how long the group lasted) to the other client progress notes.

There are two methods to copy and paste, depending on if the note has been saved or not.

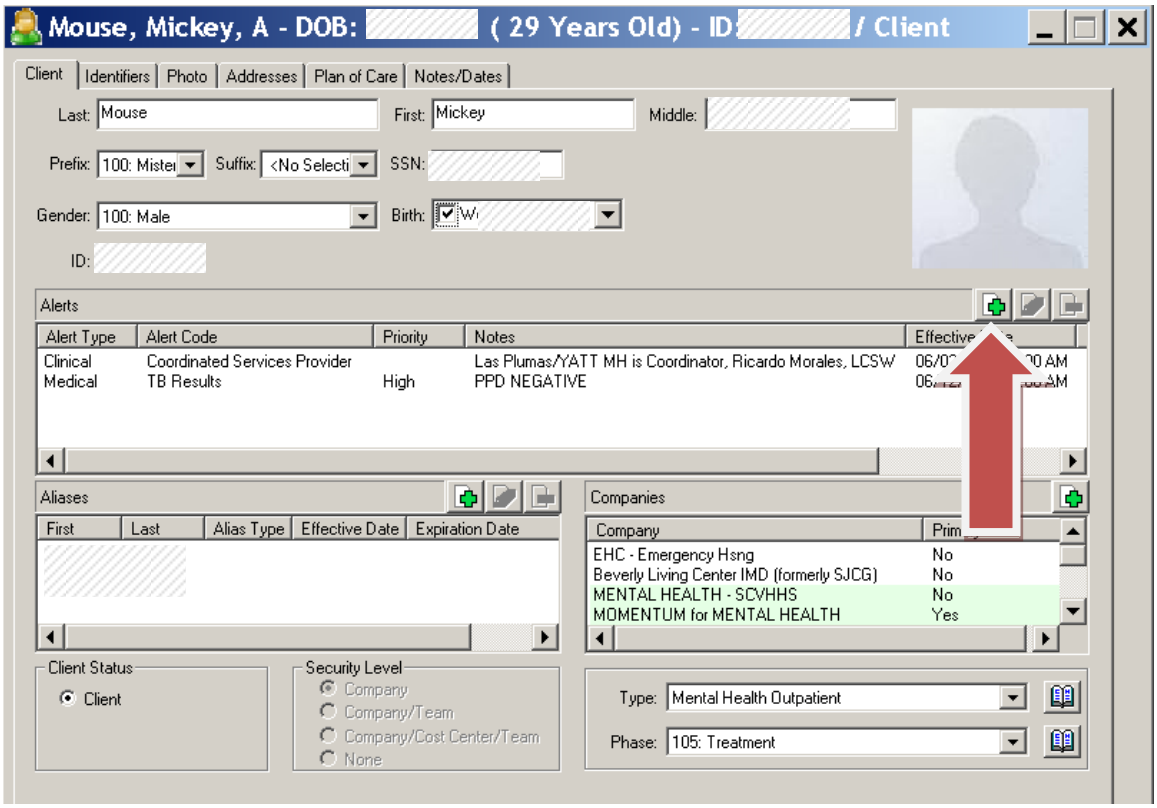
1. If the progress note has already been saved:
    a. Highlight the note you want to copy.
    b. Press Control then C on the keyboard.
    c. Go to the progress note field where you want to paste the note and click inside of the field.
    d. Press Control then V on the keyboard. The progress note should paste itself inside of the field.

2. If the progress note has not been saved:
    a. Highlight the note you want to copy.
    b. Press the copy icon in the editing tools above the progress note field.
    c. Go to the progress note field where you want to paste the note and click inside of the field.
    d. Press the paste icon in the editing tools. The progress note should paste itself inside of the field.

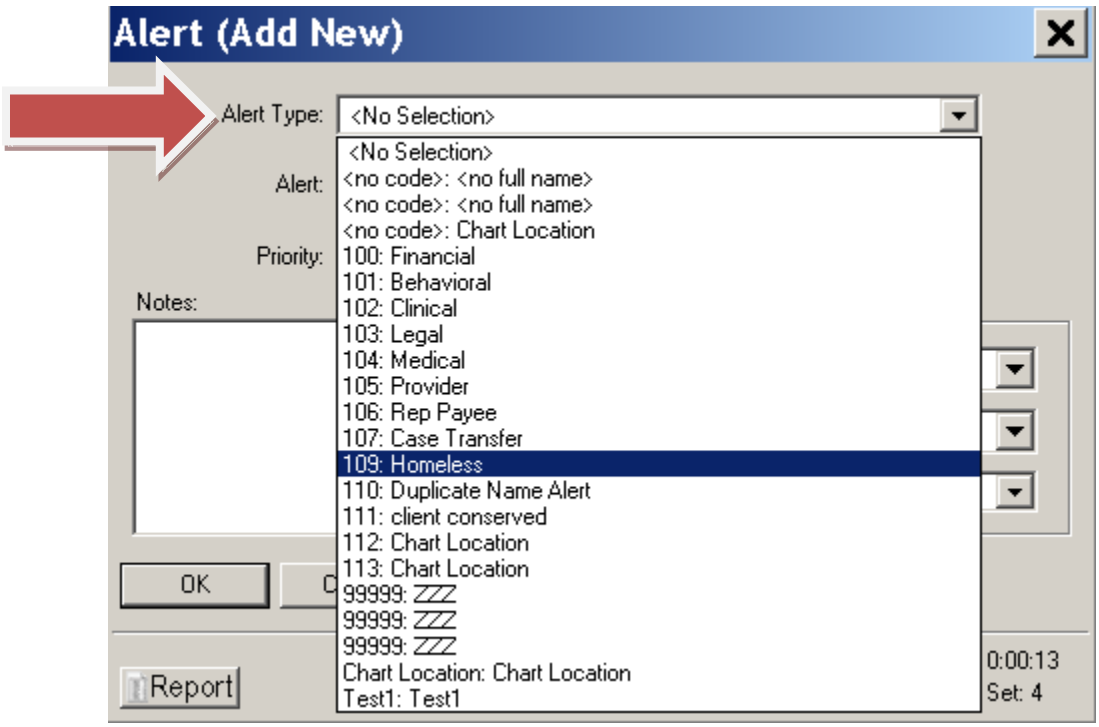
RECORDING AN ALERT

Alerts are messages that notify users of important information about a client. A common alert type is Behavior with issues such as Non-compliant, Suicidal/Homicidal ideation, Homeless, Assaultive and Runaway. Alerts are prioritized as Low, Medium or High. Space is given to add a more detailed note, if needed. Some Alerts can have a short duration and so are expired when they no longer apply. Alerts can be entered into Unicare by the Call Center, clerical or clinical staff.

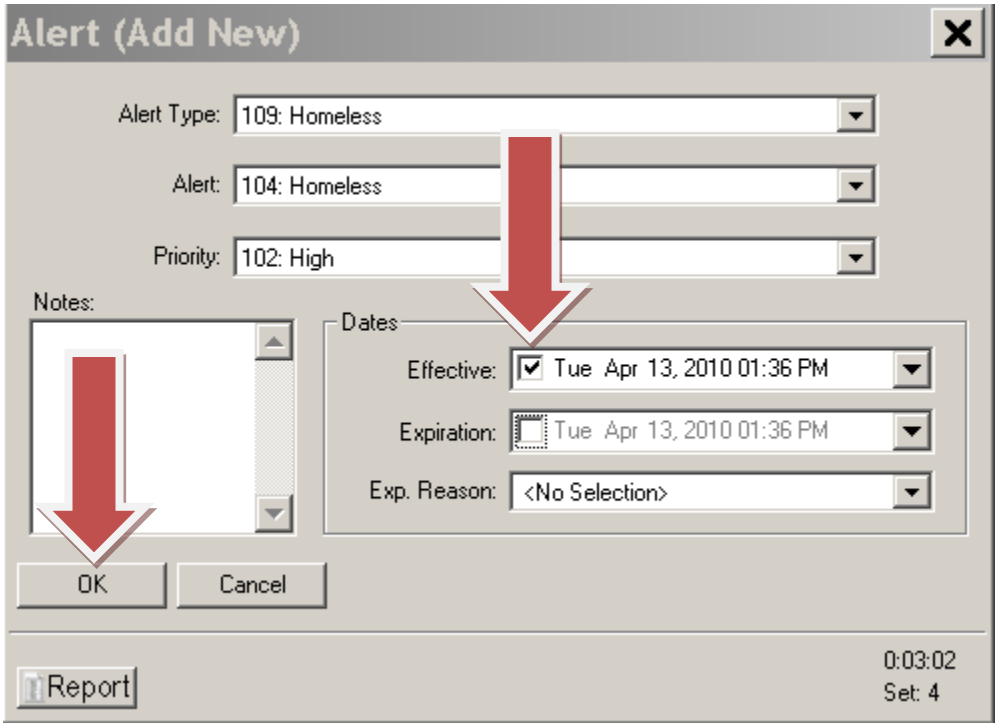
The Alerts window is on the Profile of Client screen, in the Client tab under the client's name. To add an Alert, click on the **Add** icon (green plus sign)



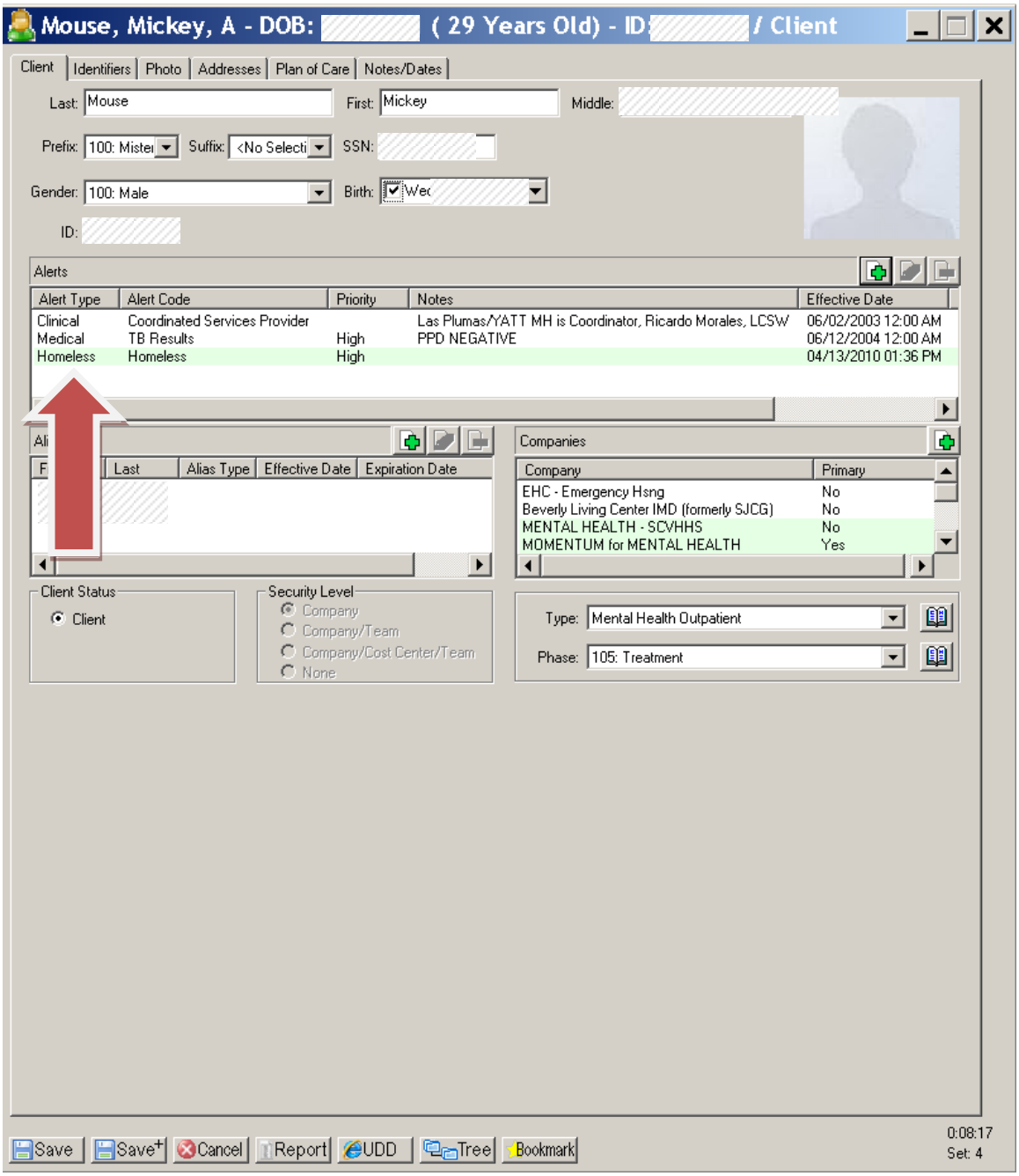
Select an **Alert Type**, **Alert** and **Priority** by clicking on their dropdown menus.



Click the **Effective Date** box, and then click the **OK** button.

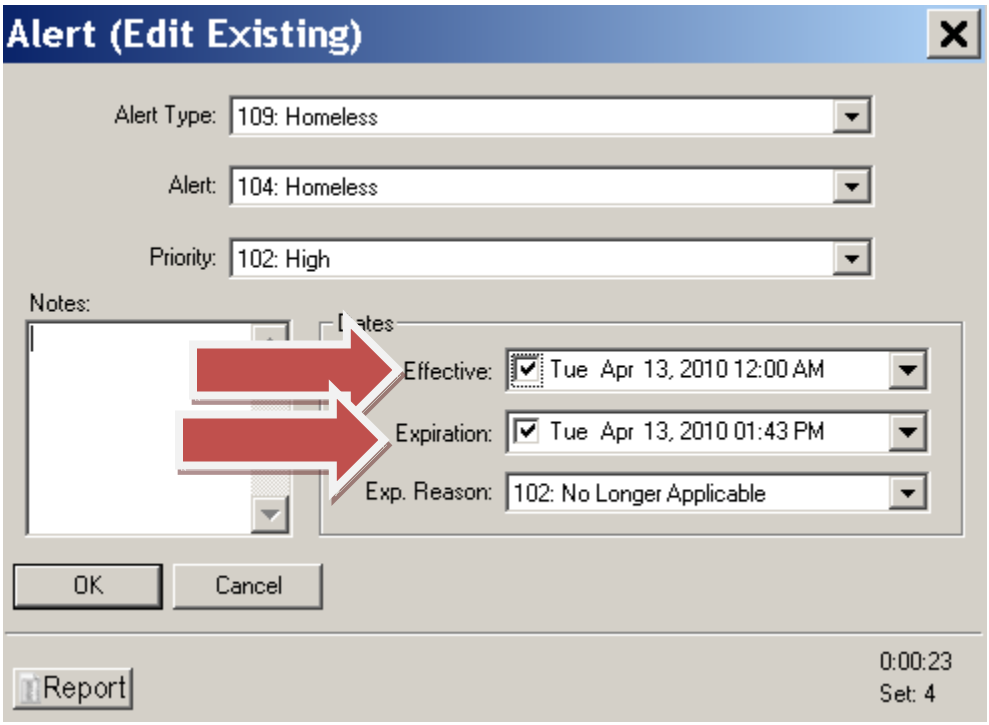


Your alert is now noted.

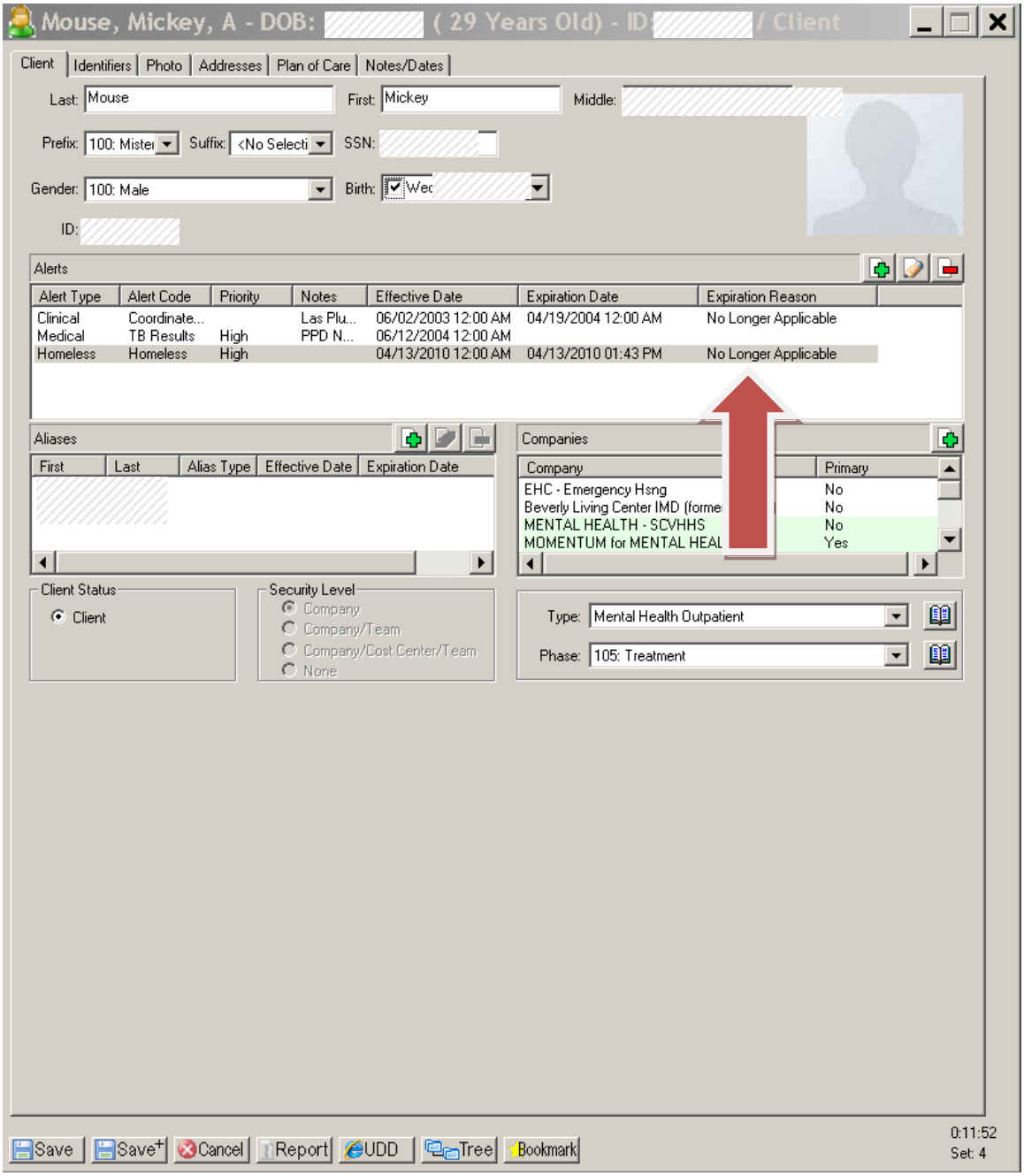


If the Alert situation changes or ends, you should expire it. Open up the Alert you made by double-clicking on it or highlighting it and clicking on the **Edit** icon (yellow pencil).

Type in a short note if needed, click the **Expiration Date** box, choose an **Expiration Reason** and then click the **OK** button.



Your Alert will remain so that there can be a history of past situations.



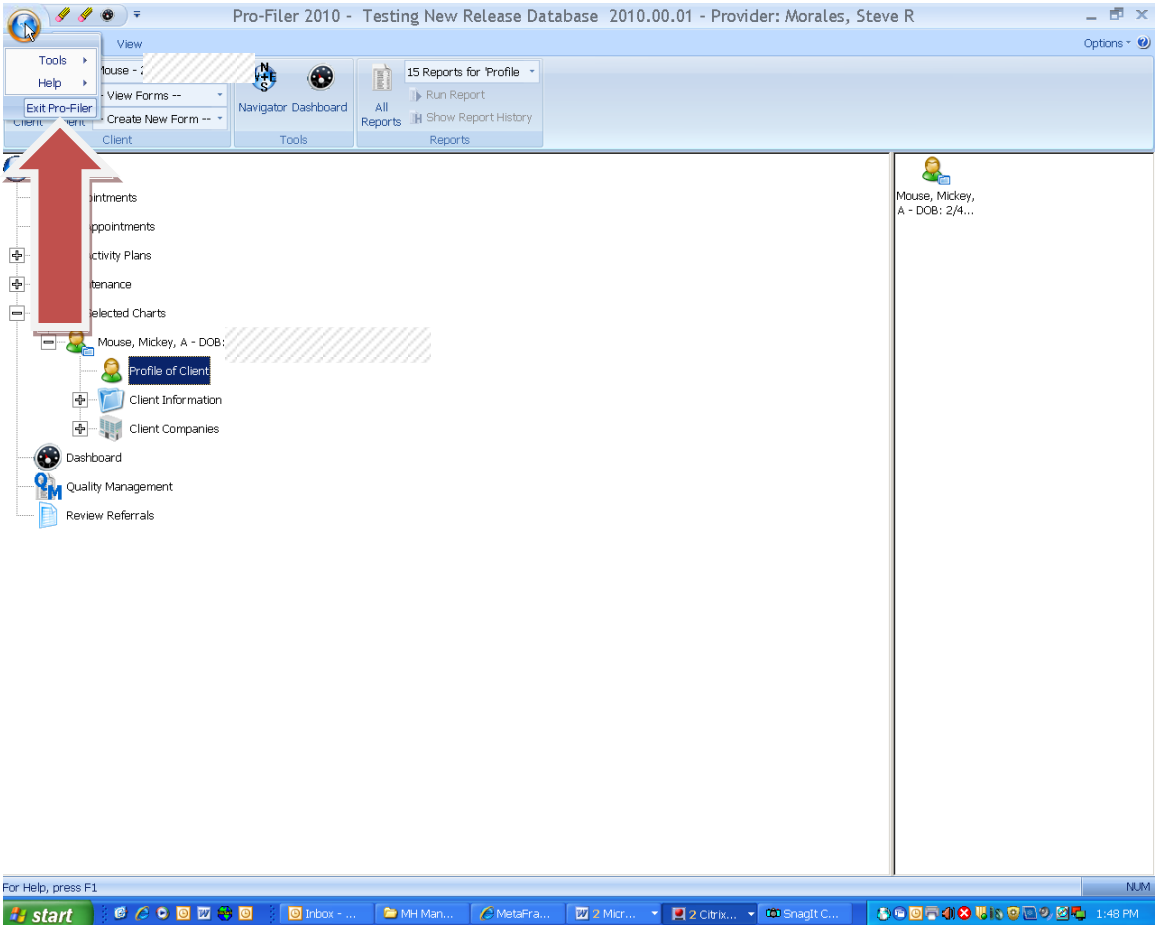
LOGGING OFF FROM UNICARE

There is a proper way to log off of Unicare. Using the correct method will insure that your client list on the Tree View will not be disturbed and any setting changes you made to the system will be saved.

Click on the **world** icon and choose **Exit Pro-filer**.

Double-clicking on the world globe will also log you off.

Note: Do not click on the X in the top right-hand corner.



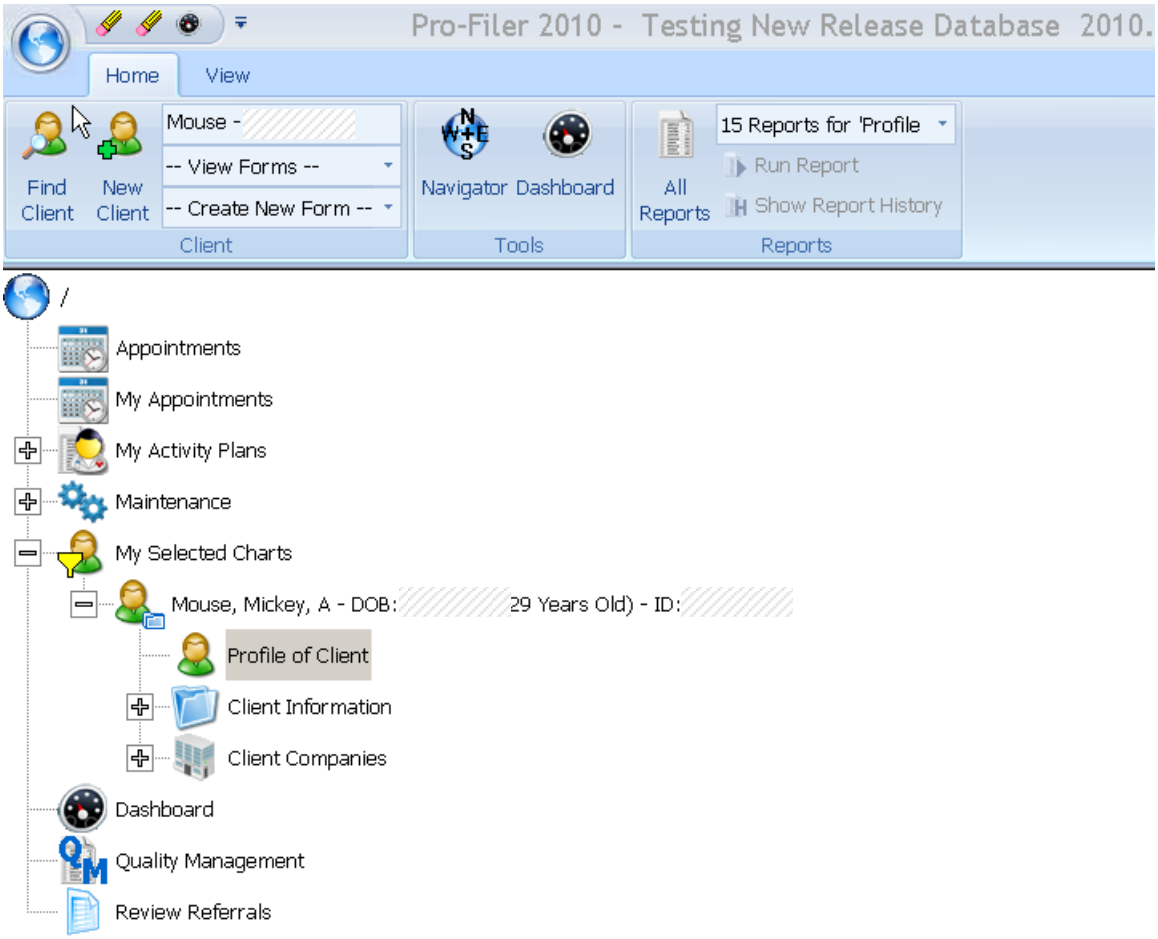
CLIENT PRIVACY AND SECURITY IN UNICARE

To help insure client privacy and security, Unicare will log you off after two hours if there is no activity. If you log back on during the second hour, Unicare will bring you back to the screen where you left off. Please save your work before you leave your workstation.

OTHER REPORTS

Authorization to access reports is given by the System Administrator. Not all users have access to the same reports.

Reports can be run at various levels on the Tree View. Reports can be run at the Root level, My Selected Charts level and the Client level.

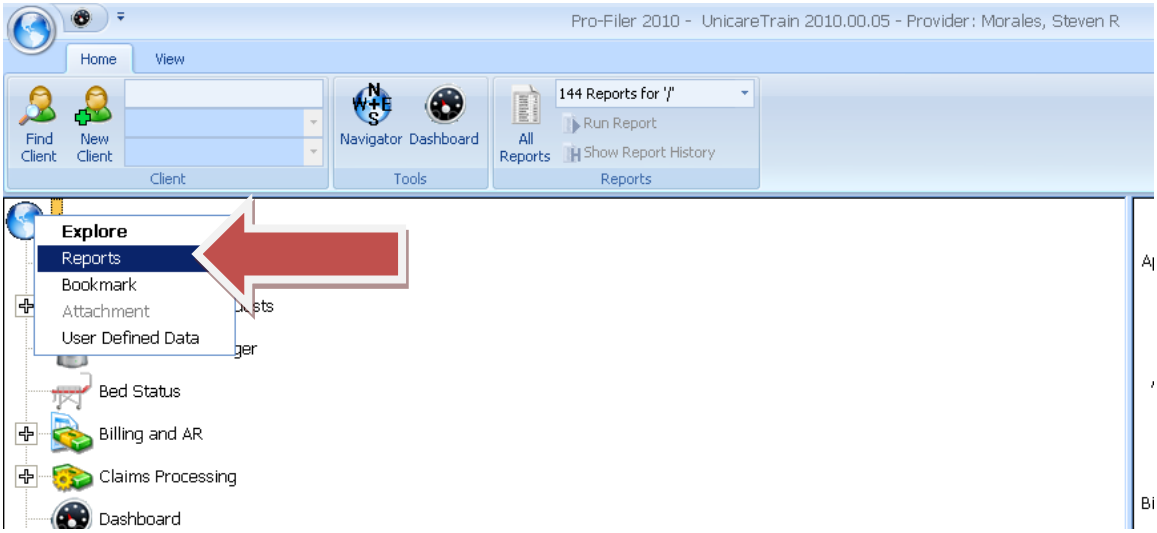


THE DAILY RECONCILIATION REPORT

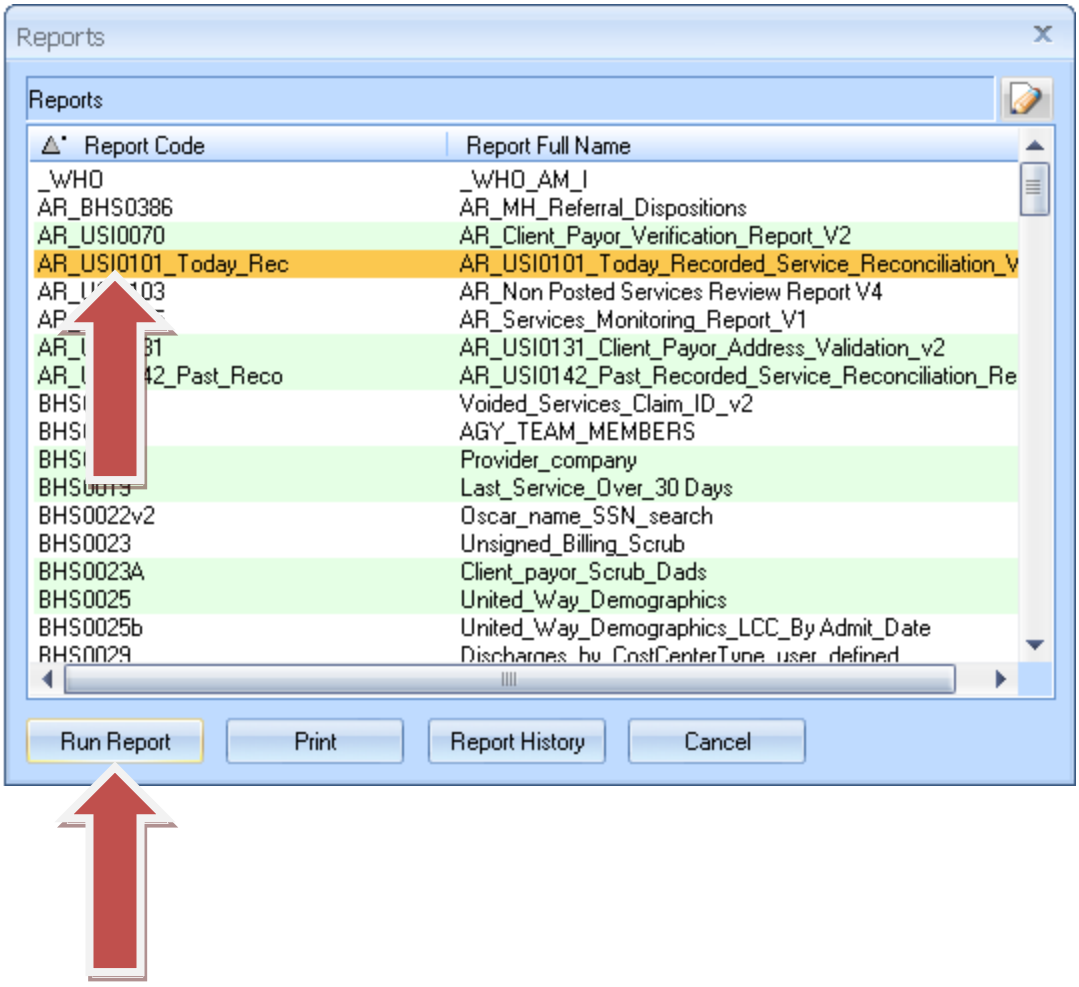
There are two Daily Reconciliation Reports; AR_USI0101 and AR_USI0142.

REMINDER: These reports are used to review information based on the date you entered a service, not the date a service was provided.

At the top of the Tree View, right click on the **Unicare icon** and choose **Reports.**



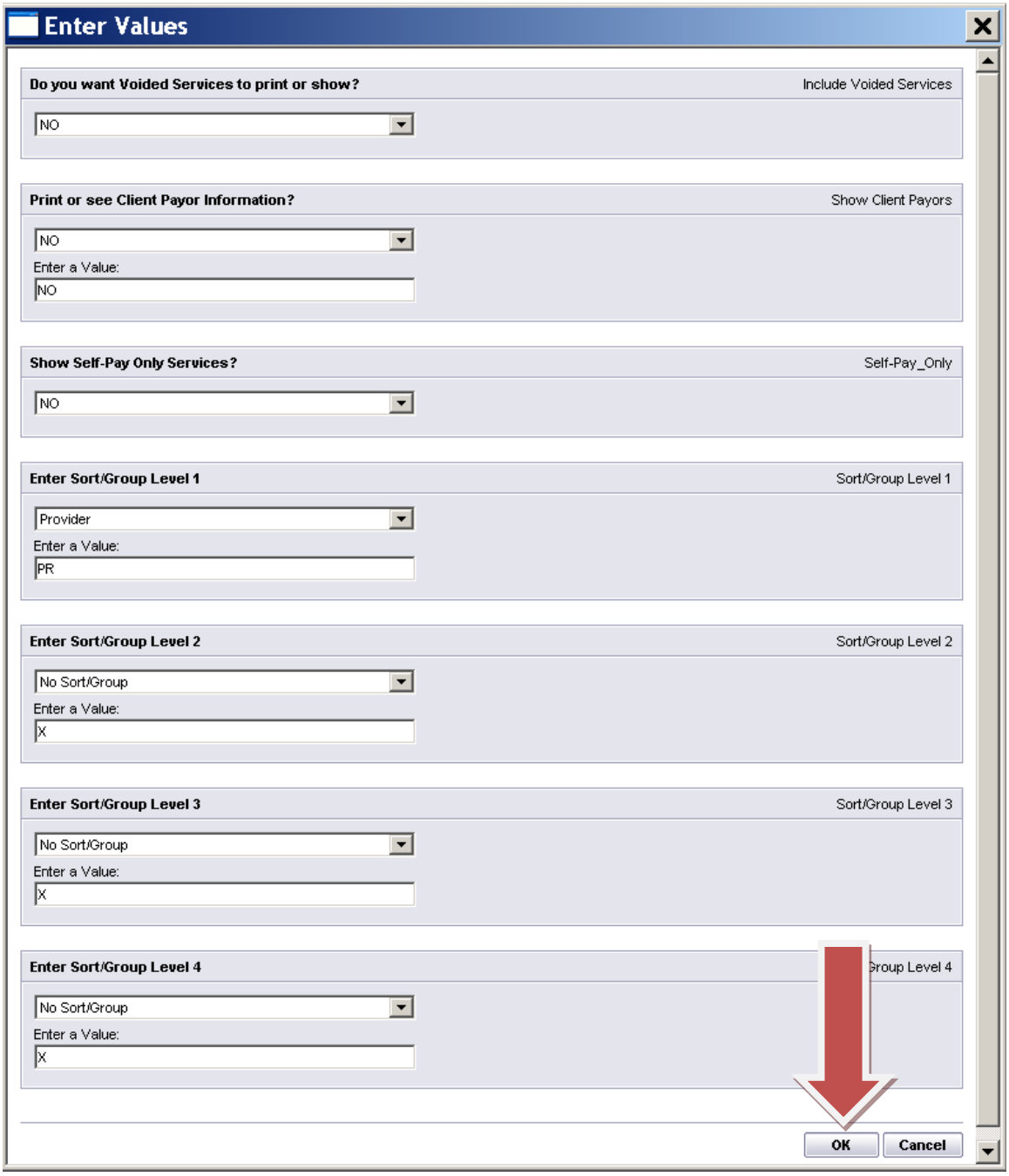
1. Choose **AR_USI0101, Today Recorded Service Reconciliation_V3**. This is to be run on a daily basis.
2. Click on **Run Report**.



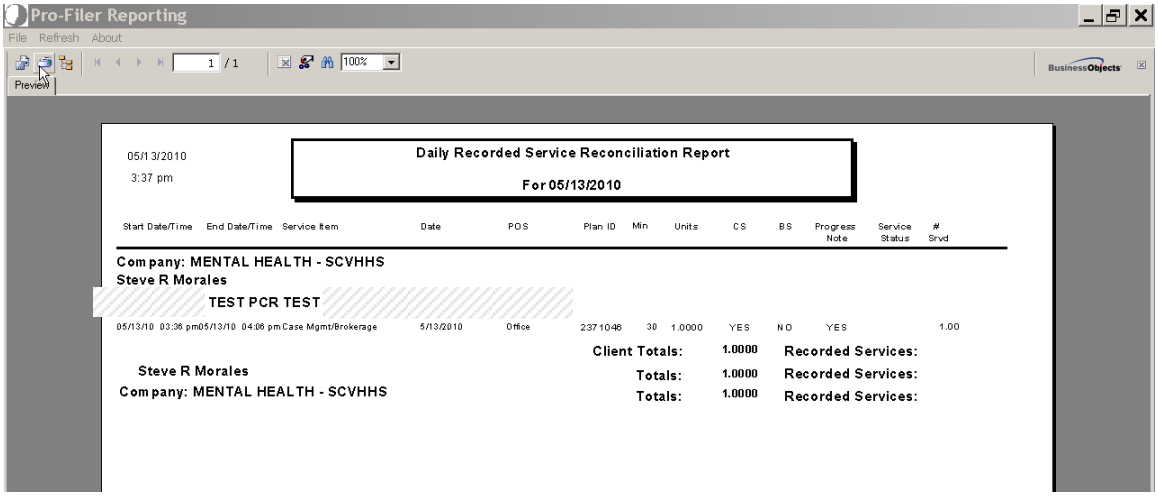
Here is the filter screen for the AR_USI 0101, Today Recorded Service Reconciliation report.

Note: the Start and End Date fields have been removed because this report knows only to look for today's entries.

1. Choose **NO** for the first two fields
2. Choose **Provider** for the Enter Sort/Group Level 1 field
3. Leave the last three fields as they are.
4. Click **OK** or press Enter on your keyboard.



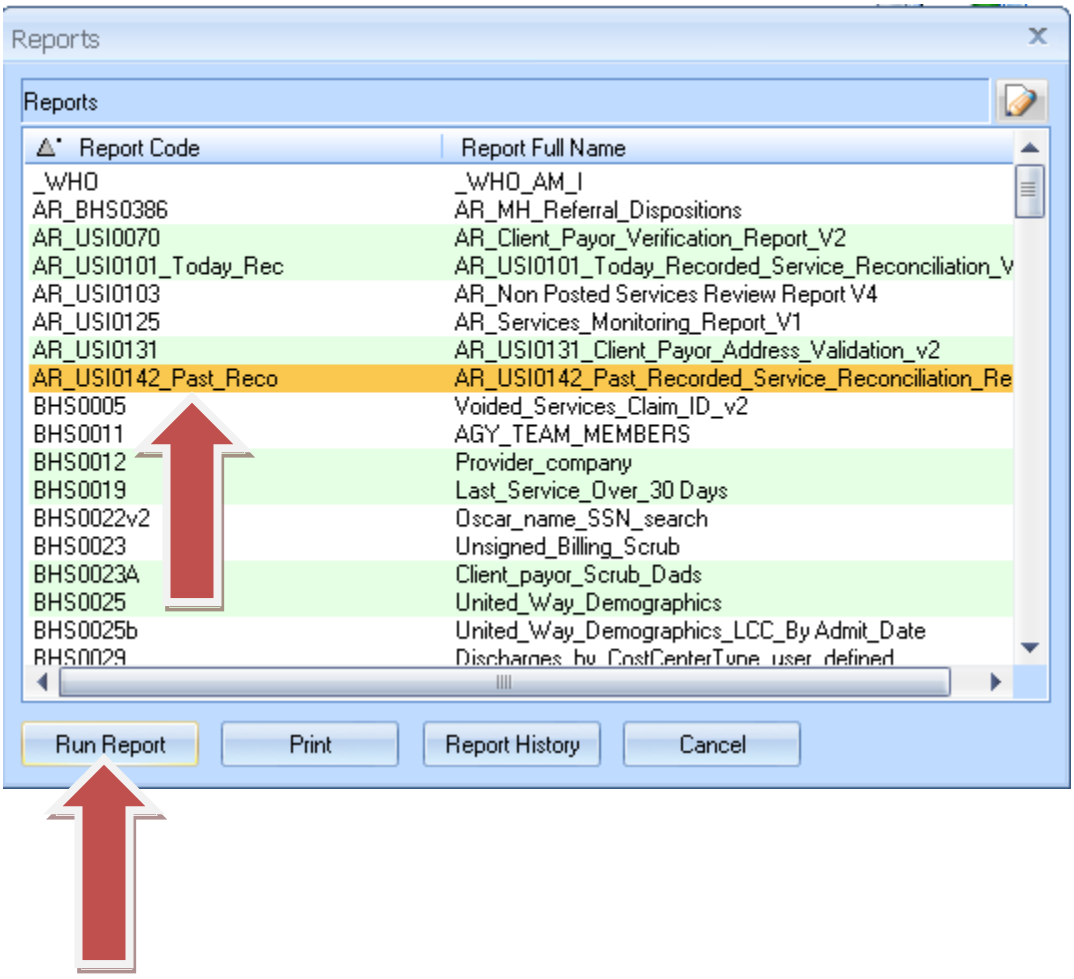
This is what your report would look like.


Pro-Filer Reporting
File Refresh About
Preview
05/13/2010
3:37 pm
Daily Recorded Service Reconciliation Report
For 05/13/2010
Start Date/Time End Date/Time Service Item Date POS Plan ID Min Units CS BS Progress Note Service Status # Srvd
Company: MENTAL HEALTH - SCVHHS
Steve R Morales
TEST PCR TEST
05/13/10 03:36 pm 05/13/10 04:06 pm Case Mgmt/Brokerage 5/13/2010 Office 2371046 30 1.0000 YES NO YES 1.00
Client Totals: 1.0000 Recorded Services:
Steve R Morales
Totals: 1.0000 Recorded Services:
Company: MENTAL HEALTH - SCVHHS
Totals: 1.0000 Recorded Services:

Verify that these items are correct:

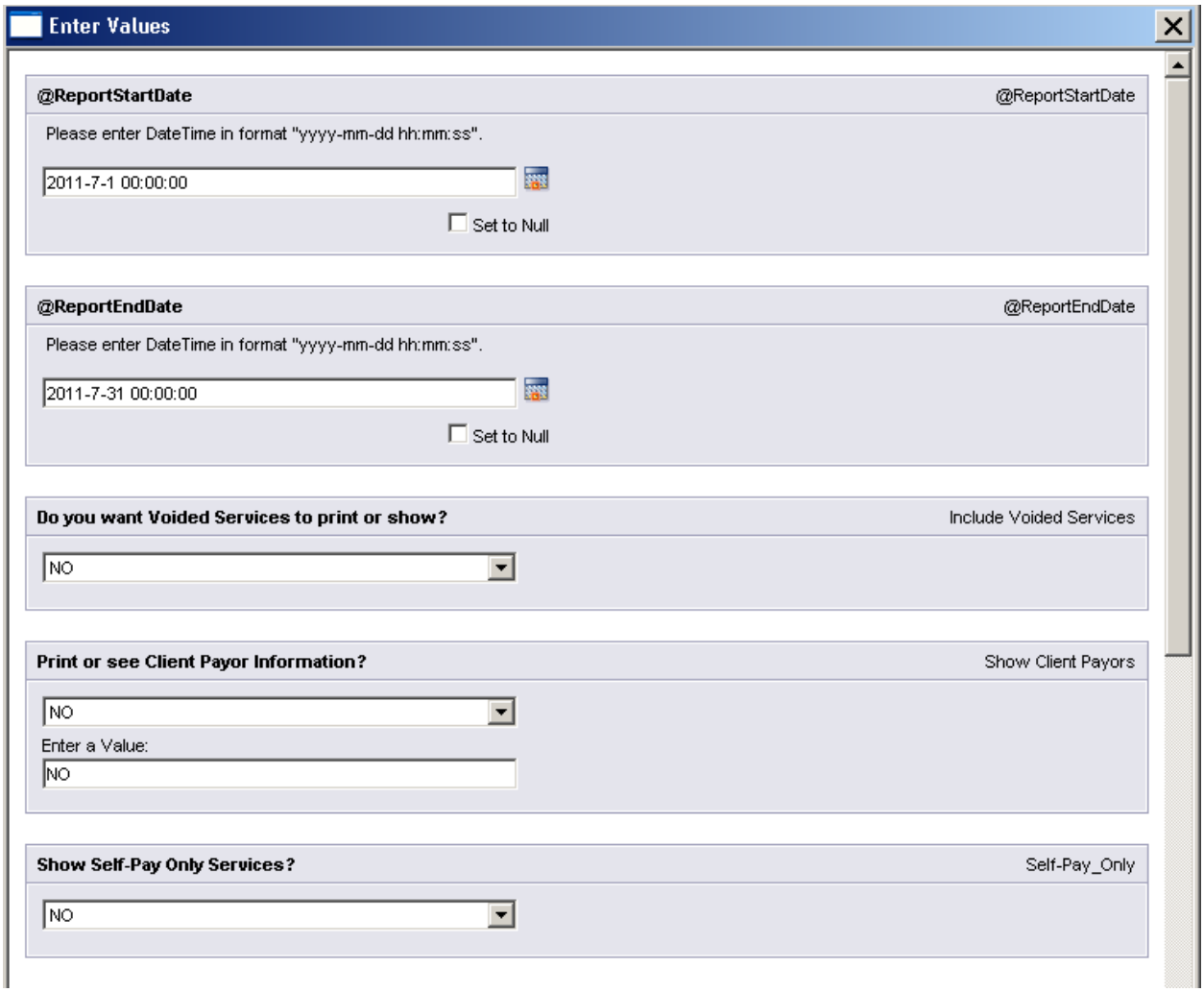
- Client name
- Service type
- Start Date/Time and End Date/Time
- POS (Place of Service)
- Units
- CS (Clinical Signed) – should be YES if box is checked on Recorded Service screen. If NO, then go back to that Recorded Service and check the box.
- BS (Billing Signed) – if NO, then you can void the service if there is a major error. If YES, then you need to contact IS to assist you in voiding the service.
- Progress Note – should be YES if you wrote one and finalized it. If it shows NO, then either you did not write a progress note or you did not finalize it.
- Service Status – only needed for Assessment, MD Assessment and Collateral services.

3. Choose **AR_USI0142, Past Recorded Service Reconciliation Report_V1**. This report is to be used to search for services entered in the past.
4. Click **Run Report**.



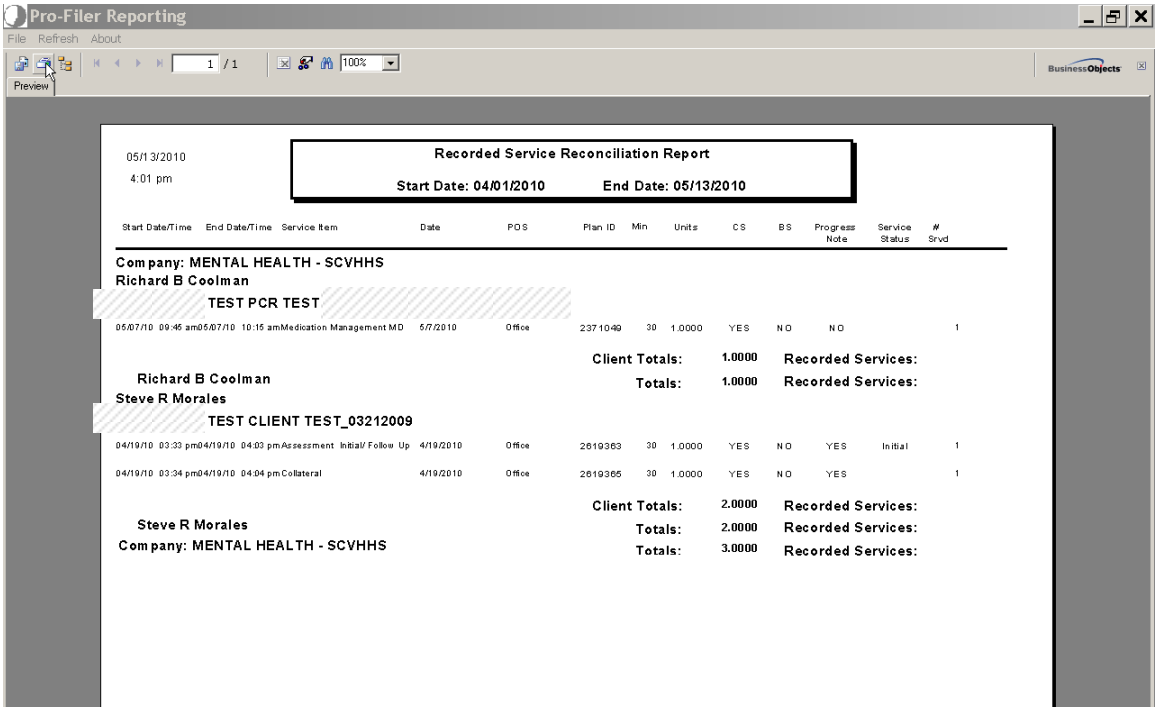
Here is the filter screen for the **AR_USI0142, Past Recorded Service Reconciliation Report**.

1. Enter your **Start Date**, which should be some time in the past.
2. Enter your **End Date.**
3. Choose **NO** for the next three fields.



1. Choose **Provider** for the Enter Sort/Group Level 1 field.
2. Leave the last three fields as they are.
3. Click **OK** or press Enter on your keyboard.

This is what your report would look like.


Pro-Filer Reporting
File Refresh About
Preview
05/13/2010
4:01 pm
Recorded Service Reconciliation Report
Start Date: 04/01/2010 End Date: 05/13/2010
Start Date/Time End Date/Time Service Item Date POS Plan ID Min Units CS BS Progress Note Service Status # Srvd
Company: MENTAL HEALTH - SCVHHS
Richard B Coolman
TEST PCR TEST
05/07/10 09:45 am 05/07/10 10:15 am Medication Management MD 5/7/2010 Office 2371049 30 1.0000 YES NO NO 1
Client Totals: 1.0000 Recorded Services:
Richard B Coolman Totals: 1.0000 Recorded Services:
Steve R Morales
TEST CLIENT TEST_03212009
04/19/10 03:33 pm 04/19/10 04:03 pm Assessment Initial/ Follow Up 4/19/2010 Office 2619363 30 1.0000 YES NO YES Initial 1
04/19/10 03:34 pm 04/19/10 04:04 pm Collateral 4/19/2010 Office 2619365 30 1.0000 YES NO YES 1
Client Totals: 2.0000 Recorded Services:
Steve R Morales Totals: 2.0000 Recorded Services:
Company: MENTAL HEALTH - SCVHHS Totals: 3.0000 Recorded Services:

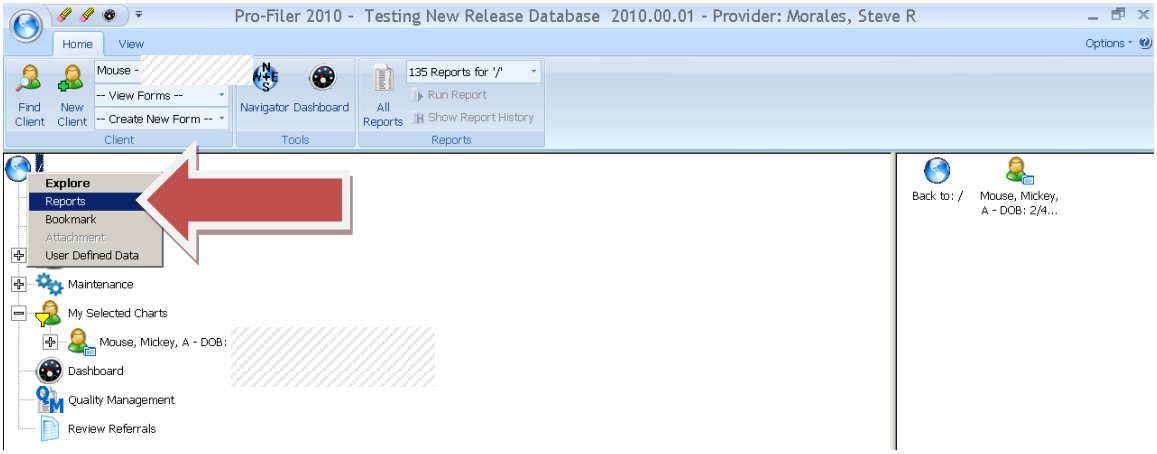
Verify that these items are correct:

- Client name
- Service type
- Start Date/Time and End Date/Time
- POS (Place of Service)
- Units
- CS (Clinical Signed) – should be YES if box is checked on Recorded Service screen. If NO, then go back to that Recorded Service and check the box.
- BS (Billing Signed) – if NO, then you can void the service if there is a major error. If YES, then you need to contact IS to assist you in voiding the service.
- Progress Note – should be YES if you wrote one and finalized it. If it shows NO, then either you did not write a progress note or you did not finalize it.
- Service Status – only needed for Assessment, MD Assessment and Collateral services.

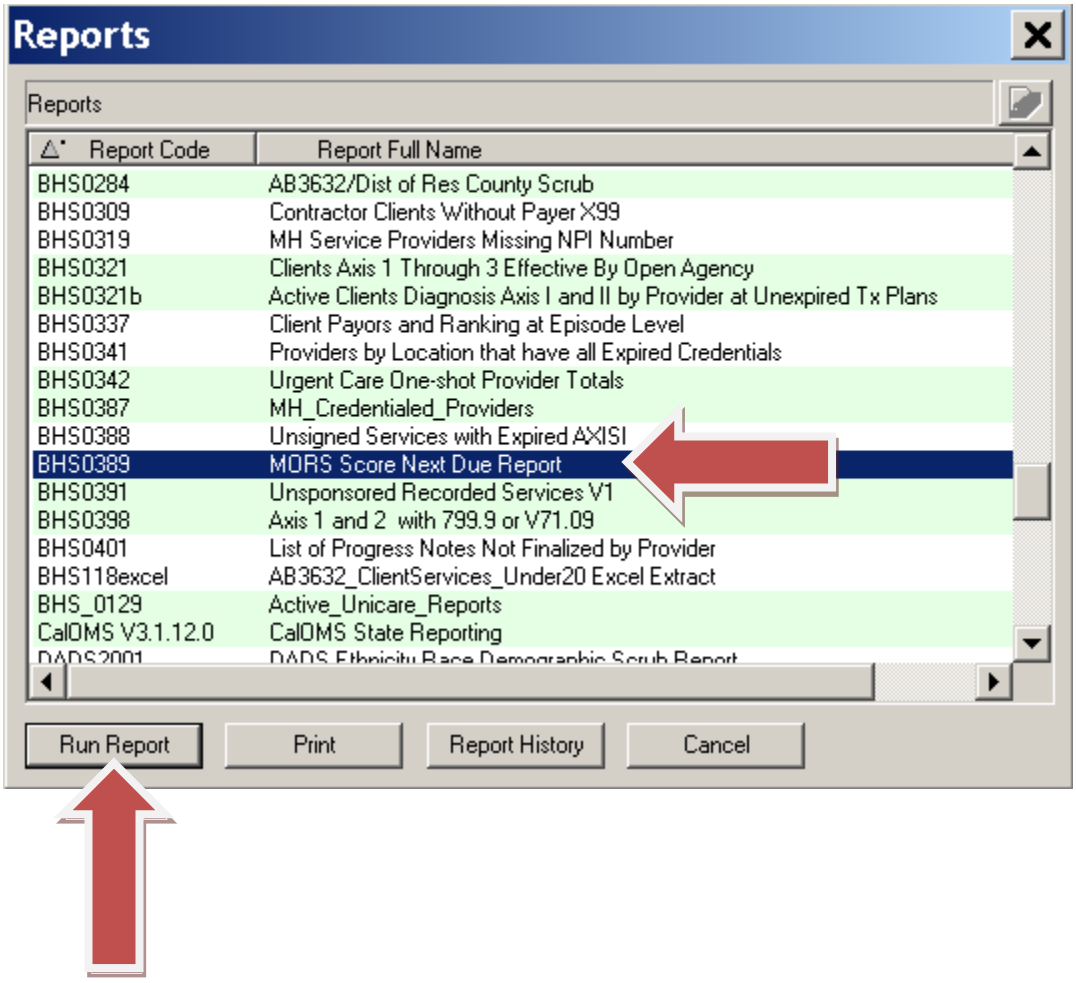
MORS SCORE NEXT DUE REPORT

This report provides **MORS** scores and the status of <u>active</u> (discharged clients are excluded) clients to remind the providers/supervisors when the next **MORS** is due on every client.

To view the report, right click at the **Root level** and choose **Reports**.

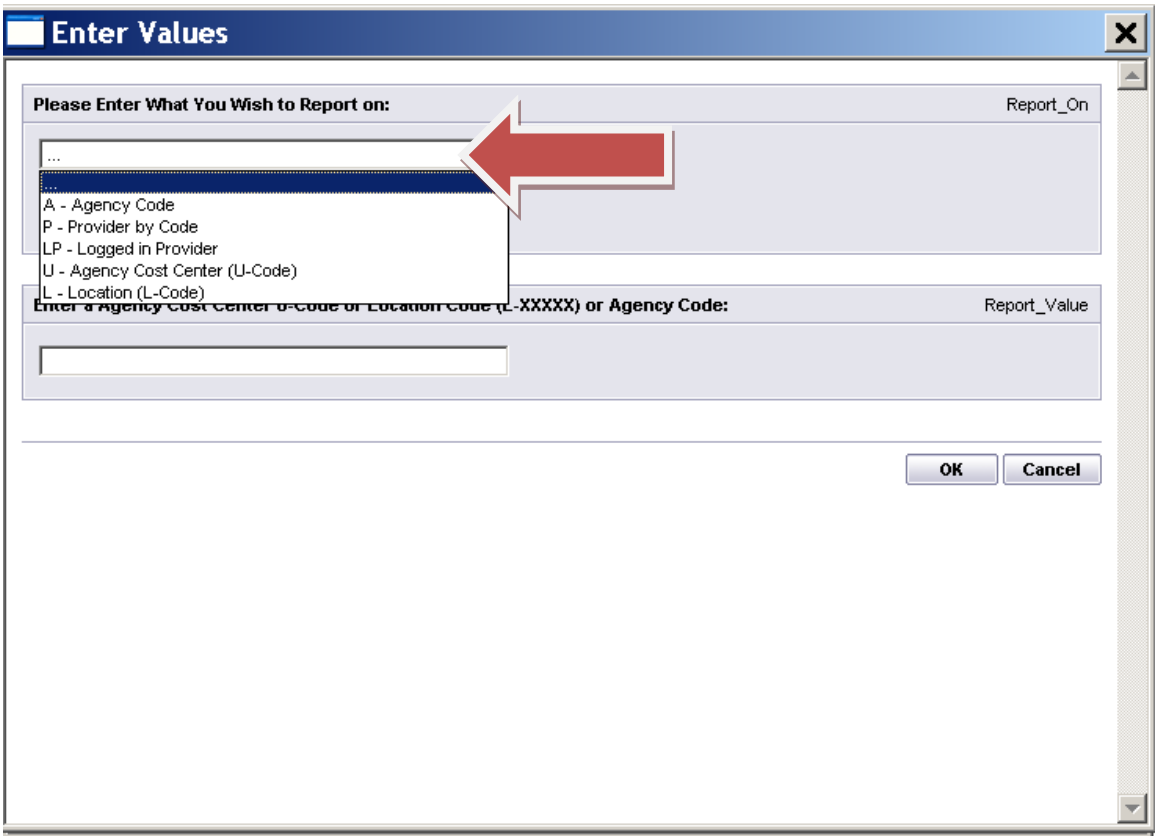


Choose **BHS0389, MORS Score Next Due Report**, then click **Run Report**.

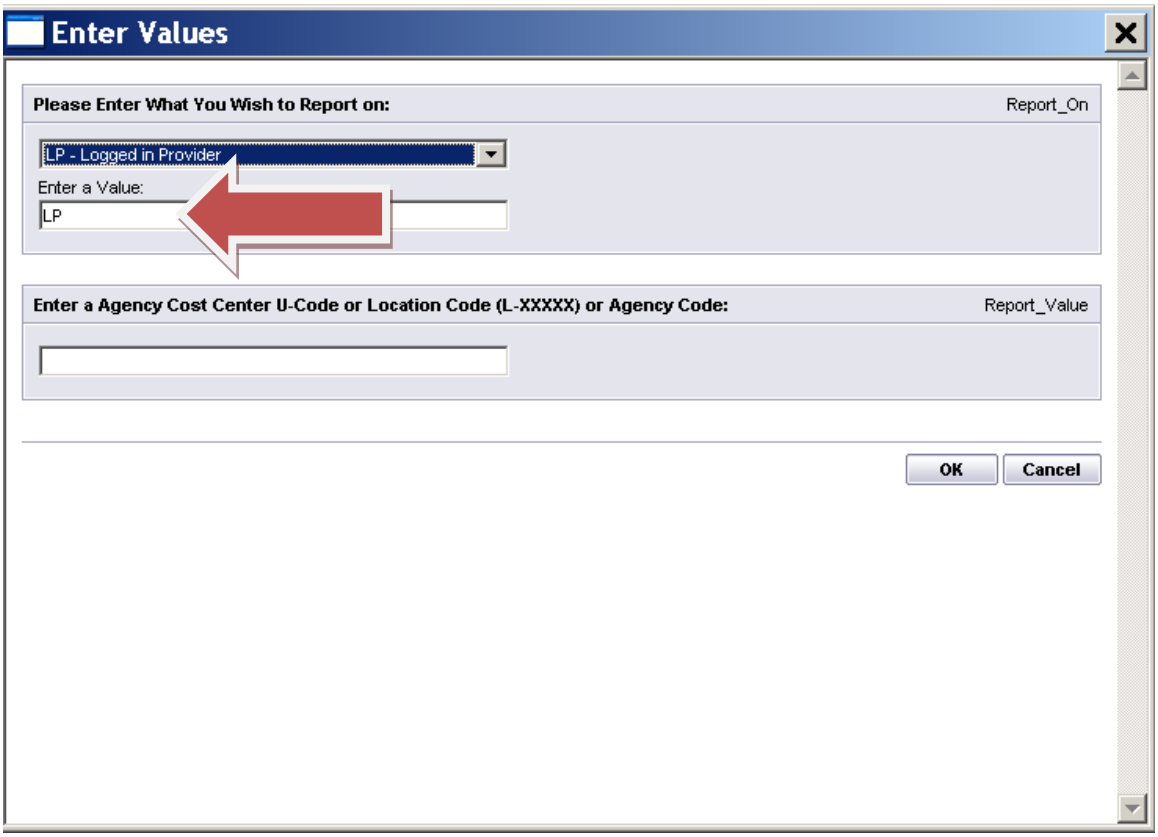

Reports
Reports
Report Code
Report Full Name
BHS0284 AB3632/Dist of Res County Scrub
BHS0309 Contractor Clients Without Payer X99
BHS0319 MH Service Providers Missing NPI Number
BHS0321 Clients Axis 1 Through 3 Effective By Open Agency
BHS0321b Active Clients Diagnosis Axis I and II by Provider at Unexpired Tx Plans
BHS0337 Client Payors and Ranking at Episode Level
BHS0341 Providers by Location that have all Expired Credentials
BHS0342 Urgent Care One-shot Provider Totals
BHS0387 MH_Credentialed_Providers
BHS0388 Unsigned Services with Expired AXISI
BHS0389 MORS Score Next Due Report
BHS0391 Unsponsored Recorded Services V1
BHS0398 Axis 1 and 2 with 799.9 or V71.09
BHS0401 List of Progress Notes Not Finalized by Provider
BHS118excel AB3632_ClientServices_Under20 Excel Extract
BHS_0129 Active_Unicare_Reports
CalOMS V3.1.12.0 CalOMS State Reporting
Run Report
Print
Report History
Cancel

1. Choose which method you will sort by:
    - Agency code or Company Code, e.g., 30000 for all County clinics.
    - Provider by Code – this is the provider that you are requesting information on
    - Logged in Provider – This is the code to choose if a provider has logged onto Unicare and wants to view the status for his/her clients
    - Agency Cost Center (U-code)
    - Location (L-Code)

If you do not know these codes, run the Who Am I report and find the clinic/agency that you need.

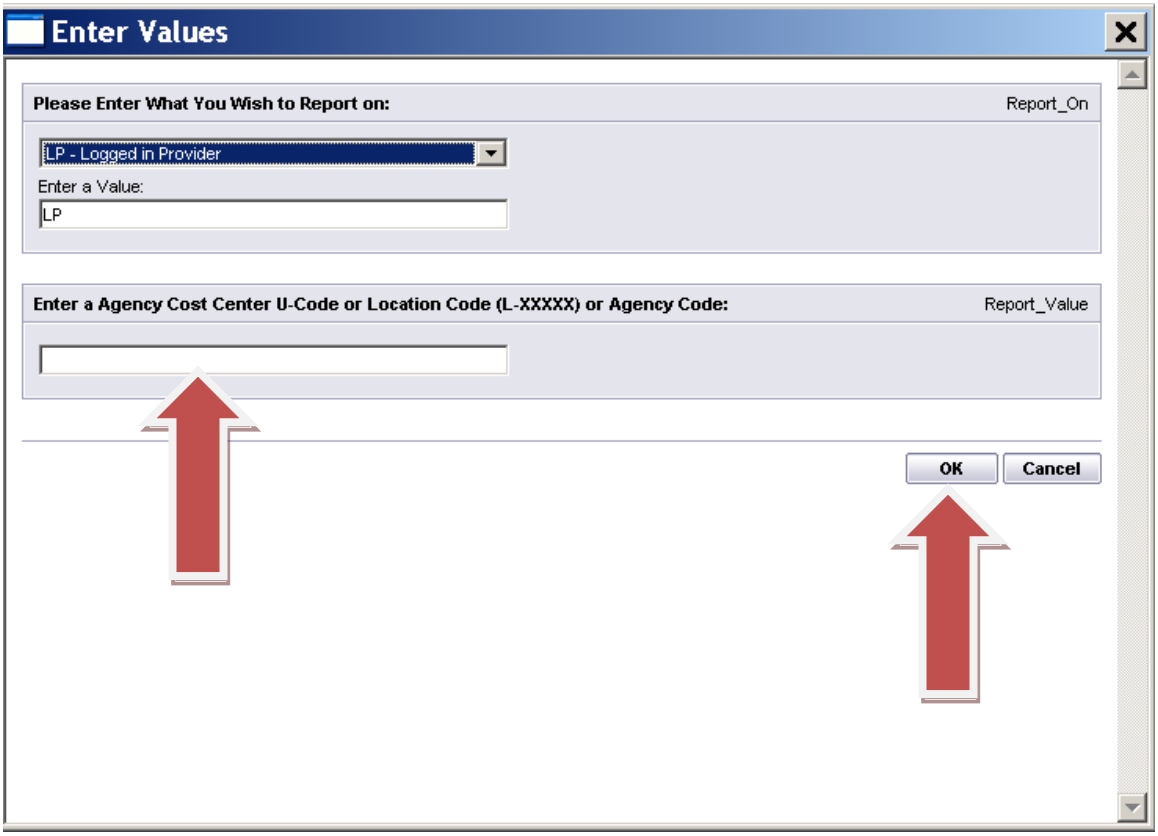


After you choose which code to sort by, Unicare will fill in the second field automatically.



2. Enter an Agency Code, Provider by Code, Location Code or Agency Cost Center.
   - Agency Code is a five-digit number, such as 30000
   - Provider by Code – enter the provider's Unicare ID number that you want data on
   - Location Code is a code that starts with an L and then has six numbers, such as L-000012
   - Agency Cost Center is also known as the U code, such as U-32

3. Click **OK** and your report is shown.

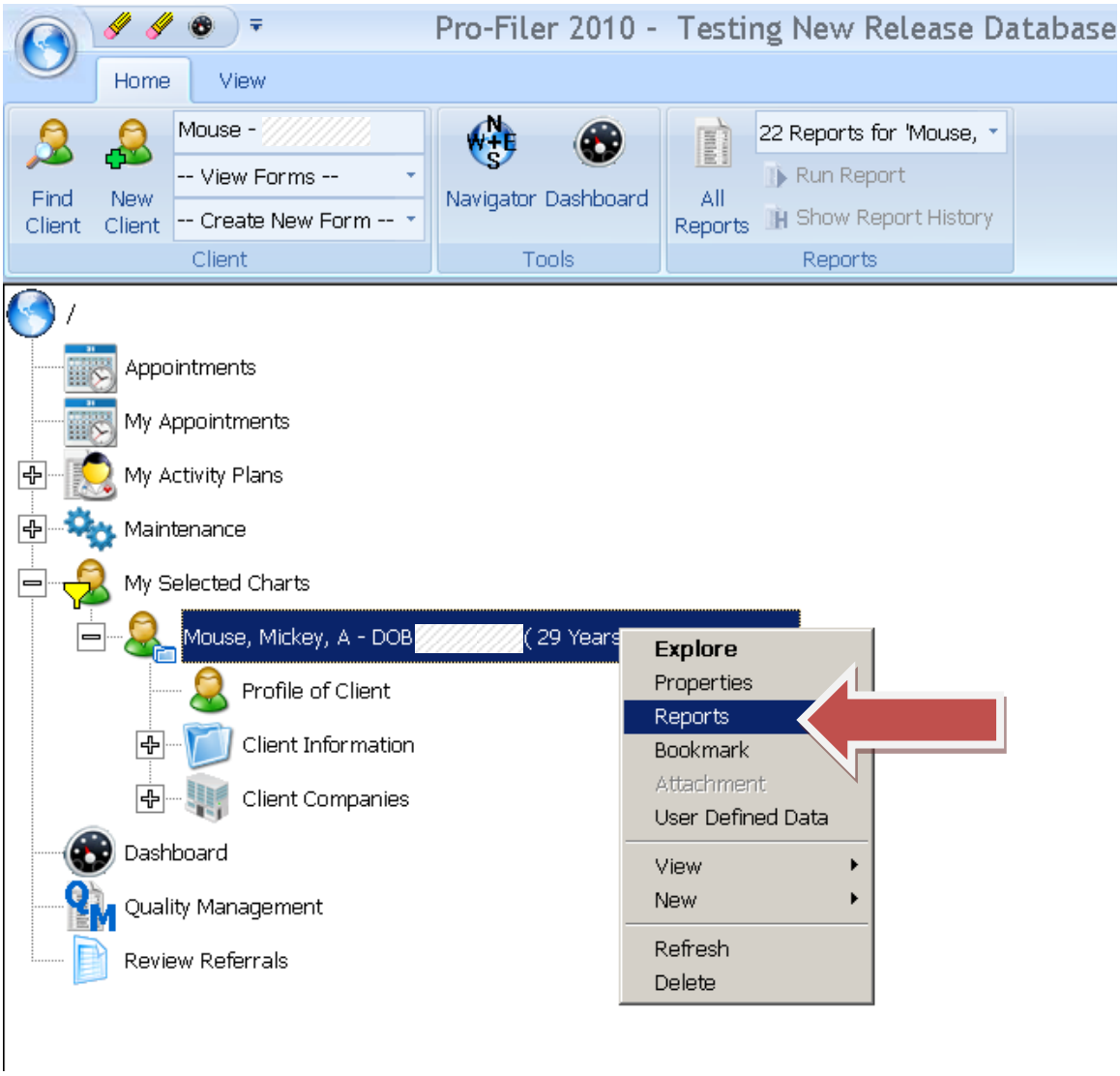


For training purposes, this report does not show any names.

FACE SHEET REPORT

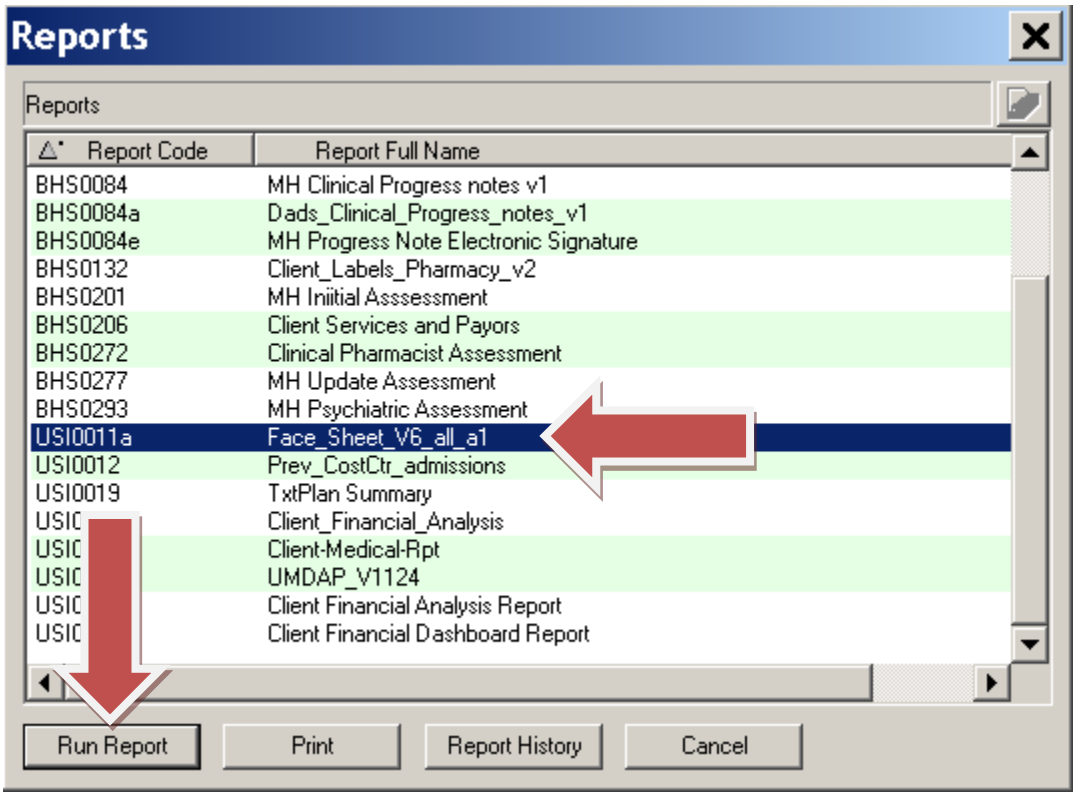
This report provides demographic information on a client.

Right click on a client's name and choose **Reports**.



The following screen will be displayed.

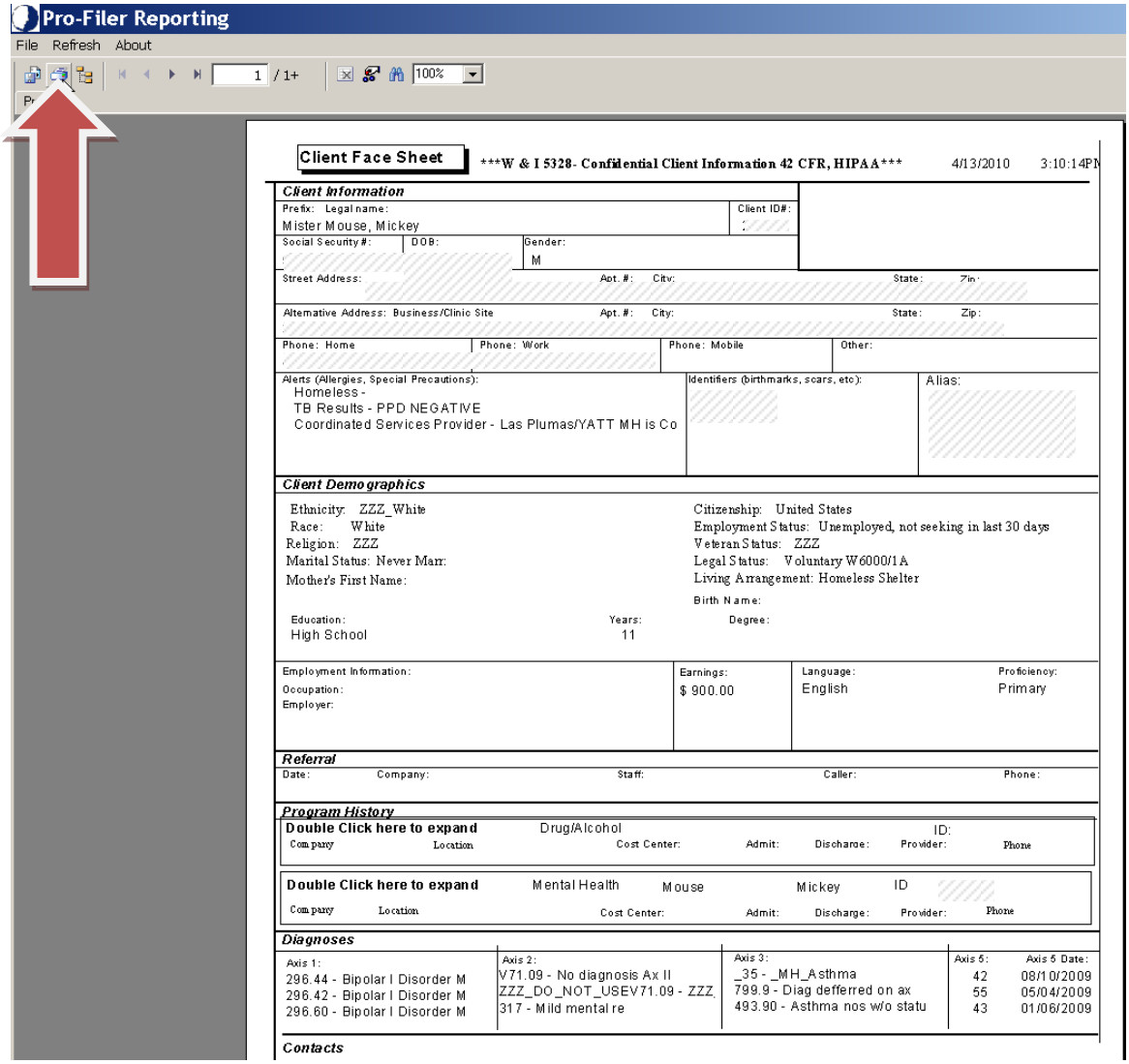
1. Highlight **USI0011a, Face_Sheet_V6_all_a1**
2. Click **Run Report**



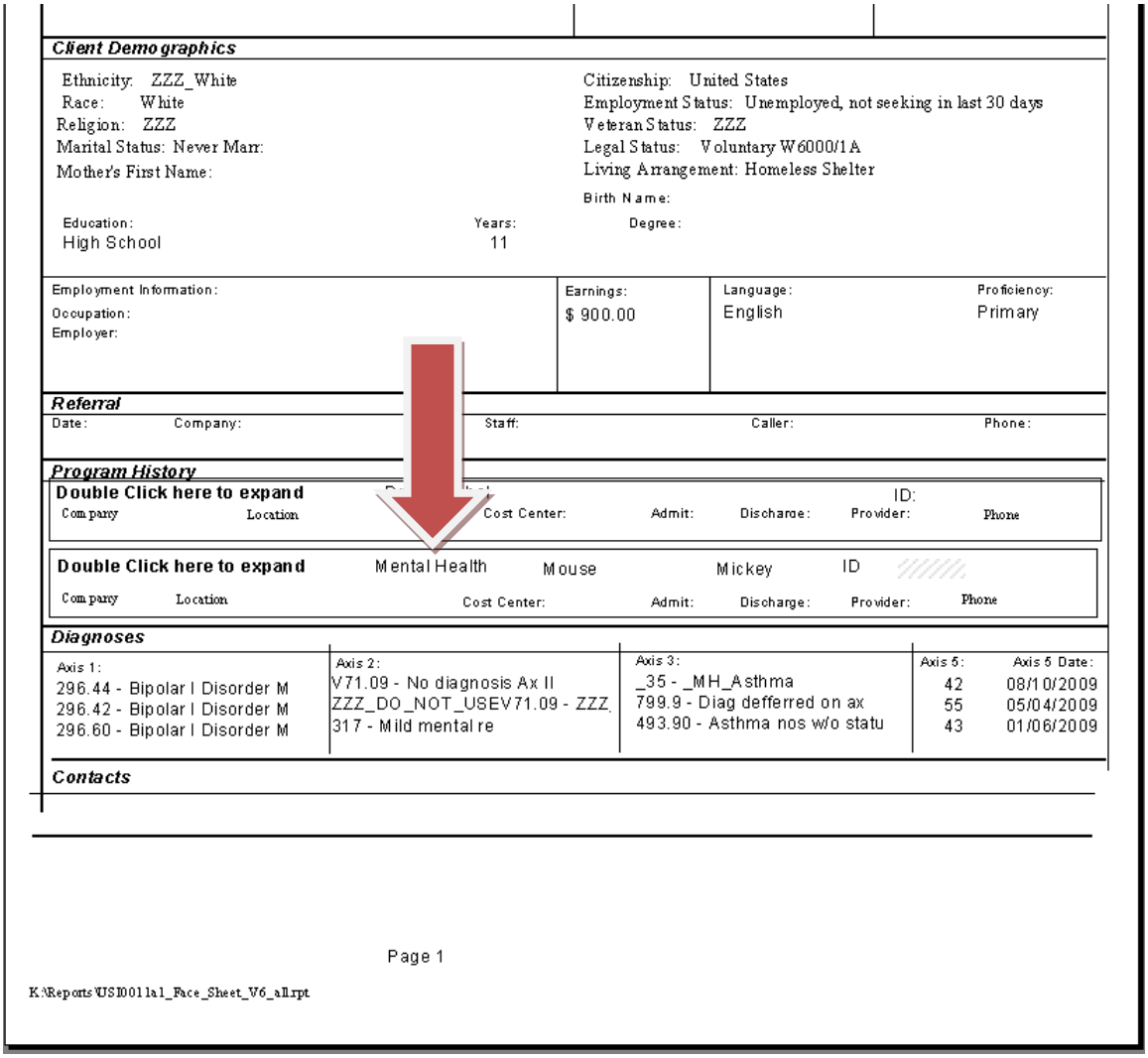
The following screen will be displayed.

This is the report.

Click the **Printer** icon if you need to print it.



Down towards the bottom of the first page, there is a section called Program History for both Drug/Alcohol and Mental Health. You cannot view the Drug/Alcohol section, but if you double-click on the Mental Health section, you will see more information on that client.



Client Demographics

Ethnicity: ZZZ_White
Race: White
Religion: ZZZ
Marital Status: Never Marr:
Mother's First Name:

Citizenship: United States
Employment Status: Unemployed, not seeking in last 30 days
Veteran Status: ZZZ
Legal Status: Voluntary W6000/1A
Living Arrangement: Homeless Shelter
Birth Name:

Education: High School
Years: 11
Degree:

Employment Information:
Occupation:
Employer:

Earnings: $ 900.00

Language: English
Proficiency: Primary

Referral

Date: Company: Staff: Caller: Phone:

Program History

Double Click here to expand ID:
Company Location Cost Center: Admit: Discharge: Provider: Phone

Double Click here to expand Mental Health Mouse Mickey ID
Company Location Cost Center: Admit: Discharge: Provider: Phone

Diagnoses

Axis 1:	Axis 2:	Axis 3:	Axis 5:	Axis 5 Date:
296.44 - Bipolar I Disorder M	V71.09 - No diagnosis Ax II	_35 - _MH_Asthma	42	08/10/2009
296.42 - Bipolar I Disorder M	ZZZ_DO_NOT_USEV71.09 - ZZZ	799.9 - Diag defferred on ax	55	05/04/2009
296.60 - Bipolar I Disorder M	317 - Mild mental re	493.90 - Asthma nos w/o statu	43	01/06/2009

Contacts

Page 1

K:\Reports\USI001la1_Face_Sheet_V6_allrpt

This shows when and where the client has received mental health services and the provider's name and phone number.

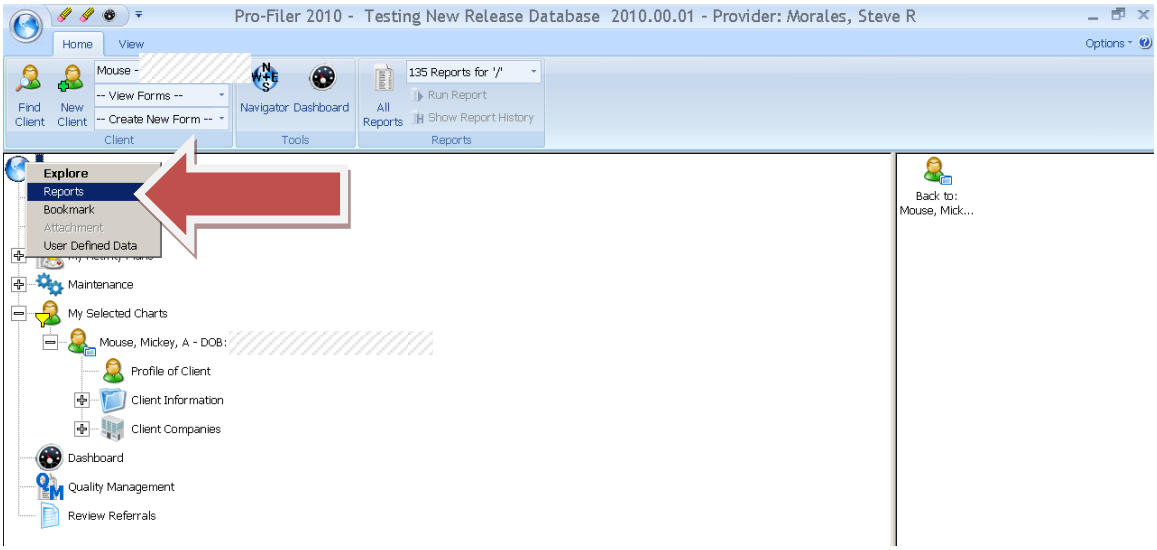
Double Click here to expand Mental Health Mouse Mickey ID

Company	Location	Cost Center:	Admit:	Discharge:	Provider:	Phone
YATT		30000 MENTAL HEALTH - SCVHHS				
L-000387	(8365) Las Plumas MH 1650 Las Plumas Ave		06/02/2003	05/11/2006	Smiddy	408.272.6729
Adult Day Socialization		31300 InnVision/MH				
L-000305	(8345) 546 W Julian St		07/23/2003	07/23/2003	Munoz	408.292.4286
Semi-Supervised Lvng/Supported Housing		31300 InnVision/MH				
L-000305	(8345) 546 W Julian St		07/23/2003	07/23/2003	Munoz	408.292.4286
EPS		30000 MENTAL HEALTH - SCVHHS				
L-000238	(4330) EPS		10/03/2003	10/04/2003	Campa	408.885.6100
EPS		30000 MENTAL HEALTH - SCVHHS				
L-000238	(4330) EPS		02/02/2004	02/03/2004	Ngo	408.885.6100
EPS		30000 MENTAL HEALTH - SCVHHS				
L-000238	(4330) EPS		02/14/2004	02/15/2004	Vedantham	
EPS		30000 MENTAL HEALTH - SCVHHS				
L-000238	(4330) EPS		02/14/2004	02/15/2004	Vedantham	
Custody OP		30000 MENTAL HEALTH - SCVHHS				
L-000291	(4326) Main Jail		04/27/2004	04/28/2004	Downing	408.286.1152
EPS		30000 MENTAL HEALTH - SCVHHS				
L-000238	(4330) EPS		04/30/2004	04/30/2004	Santos	408.885.7631
EPS		30000 MENTAL HEALTH - SCVHHS				
L-000238	(4330) EPS		05/10/2004		Downing	408.286.1152
EPS		30000 MENTAL HEALTH - SCVHHS				
L-000238	(4330) EPS		05/11/2004	05/11/2004	Slater	408.885.6100
MH Adult Crisis Residential		30700 MOMENTUM for MENTAL HEALTH				
L-000465	(8321) 436 N White Rd/Goveia-Zeller		05/21/2004	06/10/2004	Colanino	408.259.0760
MH Services in Housing Program		30700 MOMENTUM for MENTAL HEALTH				
L-000465	(8321) 436 N White Rd/Goveia-Zeller		05/21/2004	06/10/2004	Colanino	408.259.0760
EPS		30000 MENTAL HEALTH - SCVHHS				
L-000238	(4330) EPS		06/10/2004	06/10/2004	Gartner	
BAP		30000 MENTAL HEALTH - SCVHHS				
L-000195	(4330) BAP		06/10/2004	06/24/2004	Mitchell	
MH Adult Crisis Residential		30700 MOMENTUM for MENTAL HEALTH				
L-000309	(4302) 230 N. Morrison Ave SJ/SART		06/24/2004	07/26/2004	Correa	408.254.6828
MH Services in Housing Program		30700 MOMENTUM for MENTAL HEALTH				
L-000309	(4302) 230 N. Morrison Ave SJ/SART		06/24/2004	07/27/2004	Cribari	
EPS		30000 MENTAL HEALTH - SCVHHS				
L-000238	(4330) EPS		07/25/2004	07/26/2004	Slater	408.885.6100
Custody OP		30000 MENTAL HEALTH - SCVHHS				
L-000291	(4326) Main Jail		07/28/2004	07/29/2004	Frandsen	
EPS		30000 MENTAL HEALTH - SCVHHS				
L-000238	(4330) EPS		07/29/2004	07/30/2004	Gee	

WHO AM I REPORT

This report tells the Login Provider their Unicare number and information on their company, such as the Company Code, Location number and Cost Center numbers for all the programs at a company. These codes are helpful to have so that you can run other reports.

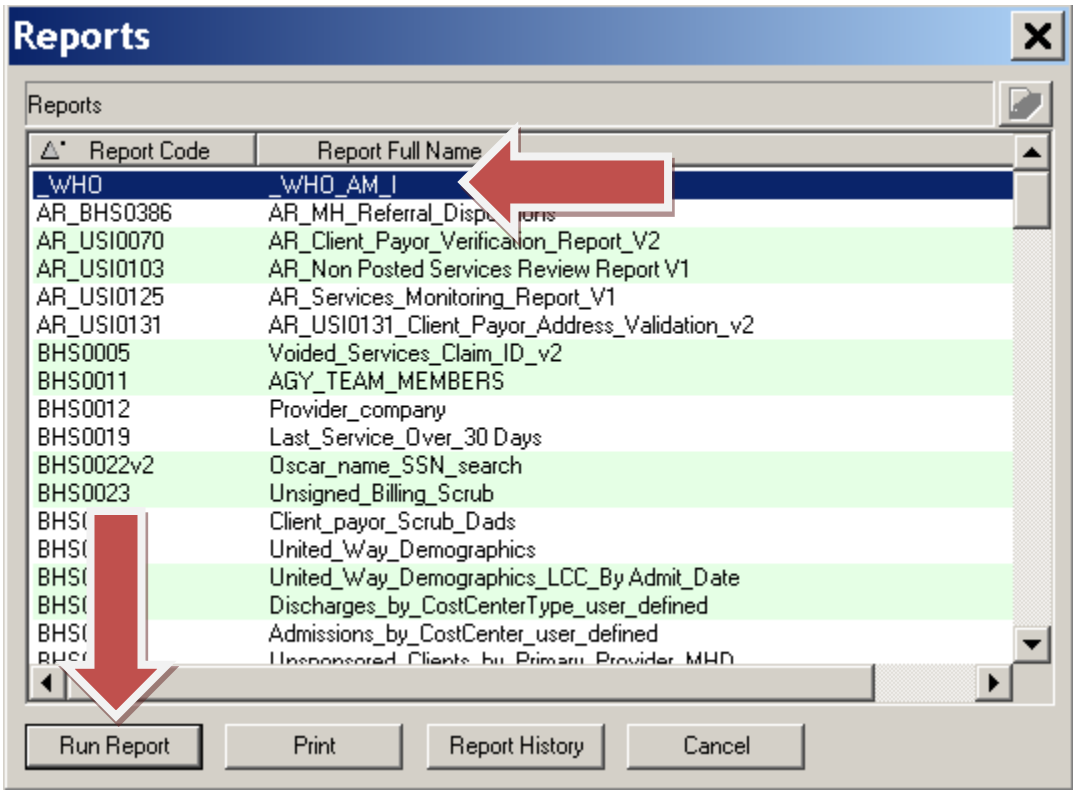
This report is available by right clicking at the **Root level** and then choosing **Reports**.



The following screen will be displayed.

There are many reports in this list. It is easier to find a particular report if you arrange the list in either numerical or alphabetical order first. Click **Report Code** or **Report Full Name** to put in order.

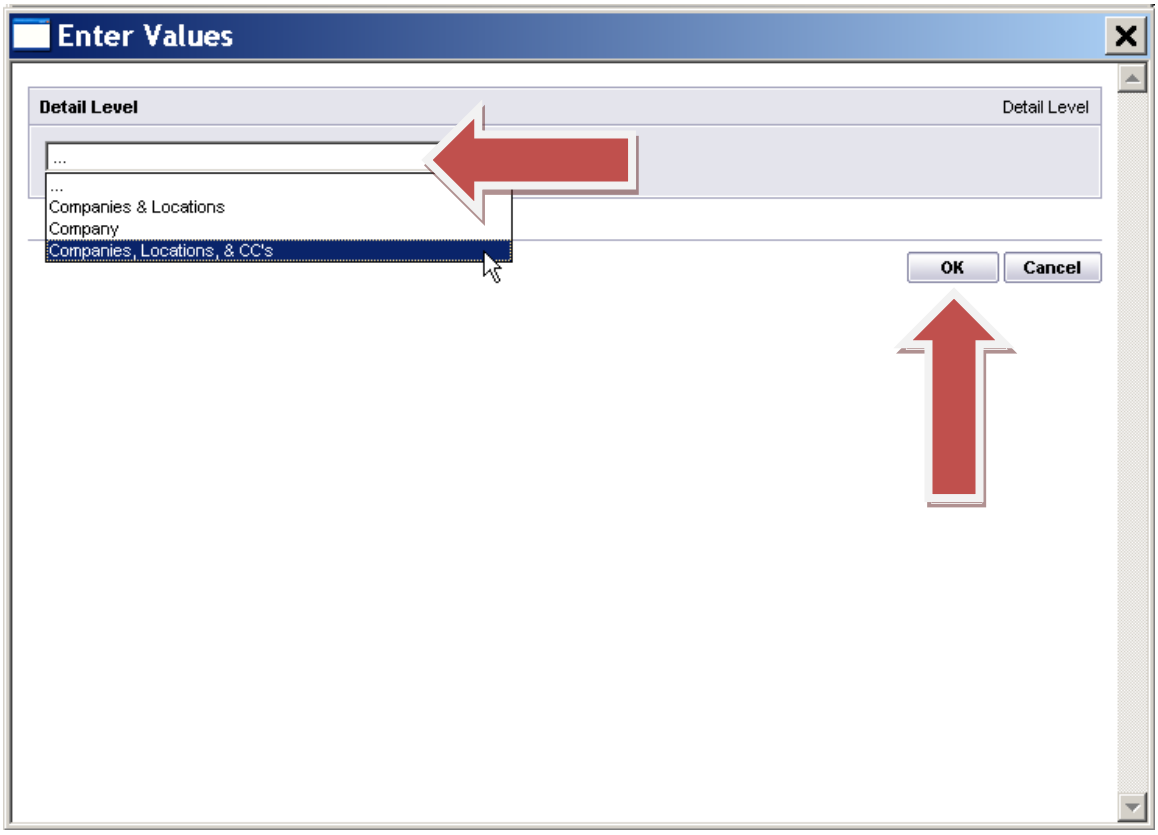
Highlight **Who Am I** and click **Run Report**.



The following screen will be displayed.

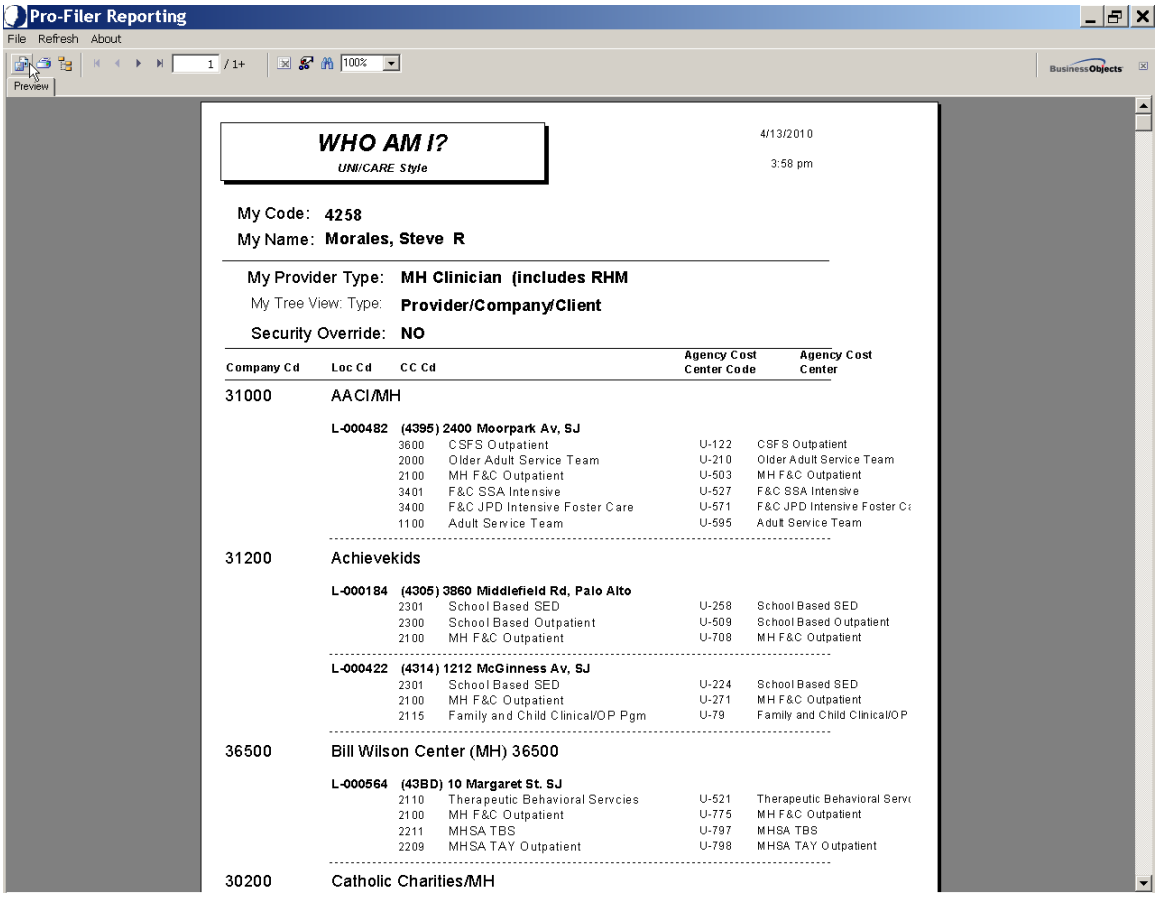
Choose **Companies, Locations, & CC's**.

Click **OK.**



The following screen will be displayed.

This report will provide you with your Unicare Provider Code, Company codes, Location codes and Cost Center codes.


Pro-Filer Reporting
File Refresh About
Preview
WHO AM I?
UNICARE Style
4/13/2010
3:58 pm
My Code: 4258
My Name: Morales, Steve R
My Provider Type: MH Clinician (includes RHM
My Tree View: Type: Provider/Company/Client
Security Override: NO
Company Cd
Loc Cd
CC Cd
Agency Cost Center Code
Agency Cost Center
31000 AACI/MH
L-000482 (4395) 2400 Moorpark Av, SJ
3600 CSFS Outpatient U-122 CSFS Outpatient
2000 Older Adult Service Team U-210 Older Adult Service Team
2100 MH F&C Outpatient U-503 MH F&C Outpatient
3401 F&C SSA Intensive U-527 F&C SSA Intensive
3400 F&C JPD Intensive Foster Care U-571 F&C JPD Intensive Foster C
1100 Adult Service Team U-595 Adult Service Team
31200 Achievekids
L-000184 (4305) 3860 Middlefield Rd, Palo Alto
2301 School Based SED U-258 School Based SED
2300 School Based Outpatient U-509 School Based Outpatient
2100 MH F&C Outpatient U-708 MH F&C Outpatient
L-000422 (4314) 1212 McGinness Av, SJ
2301 School Based SED U-224 School Based SED
2100 MH F&C Outpatient U-271 MH F&C Outpatient
2115 Family and Child Clinical/OP Pgm U-79 Family and Child Clinical/OP
36500 Bill Wilson Center (MH) 36500
L-000564 (43BD) 10 Margaret St. SJ
2110 Therapeutic Behavioral Servcies U-521 Therapeutic Behavioral Serv
2100 MH F&C Outpatient U-775 MH F&C Outpatient
2211 MHSA TBS U-797 MHSA TBS
2209 MHSA TAY Outpatient U-798 MHSA TAY Outpatient
30200 Catholic Charities/MH

APPENDIX A

CLIENT AND SERVICE INFORMATION (CSI)

Client and Service Information (CSI) is demographic and clinical data required by both the Federal government and the California State Department of Mental Health (DMH). This data is collected on all clients for all reimbursable services, no matter the billing source. This data includes such things as ethnicity, race, primary language of the client and which language the client prefers mental health services in, Axes I to V, substance abuse and trauma information, place of service and what type of, if any, evidence-based practice and/or service strategy used by the provider.

CSI data comes from both providers and clerical staff. Clerical staff enters CSI data into Unicare when registering a new client. A provider enters CSI data into Unicare when they record a service. Some CSI data is on the Open and Discharge Form that a provider fills out and gives to the clerical staff for Unicare entry. This workflow method is County-specific.

CSI GENERAL MEDICAL CONDITION SUMMARY CODES FOR AXIS III

Every provider is allowed to record an Axis III diagnosis. Best practice would be to get confirmation from a physician regarding your client's report. Providers have been using the ICD-9-CM in the back of the DSM-IV-TR. You can continue using the ICD-9-CM and record up to three codes.

The State has also developed another way to report Axis III codes. It is called the General Medical Condition (GMC) Summary Code. The codes consist of two-digit numbers. The codes are in two lists, one in numerical order, and the other in alphabetical order. You can report up to three codes from this list. If you are uncomfortable with reporting an Axis III diagnosis using the ICD-9-CM, the GMC Summary Code may be a way for you to report medical conditions in another format.

When you report Axis III, use either the ICD-9-CM codes or the GMC Summary Codes. Do not mix the codes when you report on the Open/Discharge Form.

GENERAL MEDICAL CONDITION SUMMARY CODE

Select up to three codes from the list of general medical conditions below:

01	=	Arterial Sclerotic Disease	21	=	Osteoporosis
02	=	Heart Disease	22	=	Cancer
03	=	Hypercholesterolemia	23	=	Blind / Visually Impaired
04	=	Hyperlipidemia	24	=	Chronic Pain
05	=	Hypertension	25	=	Deaf / Hearing Impaired
06	=	Birth Defects	26	=	Epilepsy / Seizures
07	=	Cystic Fibrosis	27	=	Migraines
08	=	Psoriasis	28	=	Multiple Sclerosis
09	=	Digestive Disorders (Reflux, Irritable Bowel Syndrome)	29	=	Muscular Dystrophy
10	=	Ulcers	30	=	Parkinson's Disease
11	=	Cirrhosis	31	=	Physical Disability
12	=	Diabetes	32	=	Stroke
13	=	Infertility	33	=	Tinnitus
14	=	Hyperthyroid	34	=	Ear Infections
15	=	Obesity	35	=	Asthma
16	=	Anemia	36	=	Sexually Transmitted Disease (STD)
17	=	Allergies	37	=	Other
18	=	Hepatitis			
19	=	Arthritis	99	=	Unknown / Not Reported General Medical Condition
20	=	Carpal Tunnel Syndrome	00	=	No General Medical Condition

For your convenience, below are the General Medical Condition Summary Codes displayed alphabetically:

17	=	Allergies	04	=	Hyperlipidemia
16	=	Anemia	05	=	Hypertension
01	=	Arterial Sclerotic Disease	14	=	Hyperthyroid
19	=	Arthritis	13	=	Infertility
35	=	Asthma	27	=	Migraines
06	=	Birth Defects	28	=	Multiple Sclerosis
23	=	Blind / Visually Impaired	29	=	Muscular Dystrophy
22	=	Cancer	00	=	No General Medical Condition
20	=	Carpal Tunnel Syndrome	15	=	Obesity
24	=	Chronic Pain	21	=	Osteoporosis
11	=	Cirrhosis	37	=	Other
07	=	Cystic Fibrosis	30	=	Parkinson's Disease
25	=	Deaf / Hearing Impaired	31	=	Physical Disability
12	=	Diabetes	08	=	Psoriasis
09	=	Digestive Disorders (Reflux, Irritable Bowel Syndrome)	36	=	Sexually Transmitted Disease (STD)
34	=	Ear Infections	32	=	Stroke
26	=	Epilepsy / Seizures	33	=	Tinnitus
02	=	Heart Disease	10	=	Ulcers
18	=	Hepatitis	99	=	Unknown / Not Reported General Medical Condition
03	=	Hypercholesterolemia			

APPENDIX B

CSI DICTIONARY FOR PLACE OF SERVICE

The California Department of Health Services developed the Place of Service dictionary. There are 19 choices.

PLACE OF SERVICE
June 7, 2006

A = Office [formerly "Office (including phone)"]

Definition: Services are provided in a location, other than a hospital, skilled nursing facility (SNF), correctional facility, public health clinic or facility supplying residential care, where the mental health professional routinely provides assessments, diagnosis, and mental health treatment on an ambulatory basis.

B = Field (unspecified) [formerly "Field (when location is away from the clinician's usual place of business, except for Correctional Institution and Inpatient)"].

Definition: Services are provided in an unspecified location away from the clinician's usual place of business, except for Correctional Institution, Inpatient, or Residential Care for adults or children.

C = Correctional Facility (e.g., Jail, Prison, camp/ranch, etc.) [Formerly "Correctional Institution"]

Definition: Services are provided in a correctional facility, including adult or juvenile detention facilities.

D = Inpatient (e.g., Hospital, Psychiatric Health Facility (PHF), Skilled Nursing Facility (SNF), Institute for Mental Disease (IMD), Mental Health Rehabilitation Center (MHRC).

Definition: Services are provided in a facility, which primarily provides diagnostic, therapeutic, and rehabilitative services. Includes hospitals, psychiatric health facilities (PHF), skilled nursing facilities (SNF), Institutes for Mental Disease (IMD's), Mental Health Rehabilitation Centers (MHRC).

E = Homeless / Emergency Shelter

Definition: Services are provided in a facility specifically designed to provide shelter to the general homeless population.

F = Faith-based (e.g., church, temple, etc.)

Definition: Services are provided in a location owned or leased by a faith group, with partial or full involvement of the faith group.

G = Health Care / Primary Care

Definition: Services are provided by the consumer's primary care or general health care provider, or in the clinic or facility of the health care provider, including emergency room and public health clinics.

H = Home

Definition: Services are provided at a location, other than a hospital or other facility, where the client receives care in a private residence.

I = Age-Specific Community Center

Definition: Services are provided in a location owned or leased by an age-specific community center, such as a senior's center, a teen drop-in center, etc.

J = Client's Job Site

Definition: Services are provided at the client's site of employment.

L = Residential Care – Adults

Definition: Services are provided in a location supplying 24-hr non-medical care for adults, not including inpatient hospital, psychiatric health facilities (PHFs), skilled nursing facilities (SNFs), Institutes for Mental Disease (IMDs), Mental Health Rehabilitation Centers (MHRCs), or homeless/emergency shelters. Includes assisted living facilities for adults such as group homes.

M = Mobile Service

Definition: This definition is consistent with the concept of a Mobile Clinic. Mobile clinics provide services to individuals in rural or outlying areas where services are otherwise inaccessible. The concept of mobile services is in contrast to services provided at other community locations (see other listed service settings) that are reached by vehicle.

N = Non-Traditional service location (e.g., park bench, on street, under bridge, abandoned building)

Definition: Services are provided in the community, but not in a community center, school, faith-based location, homeless/emergency shelter, health-care center, or the client's job site. Examples include park bench, on the street under a bridge, in an abandoned building, etc.

O = Other Community location

Definition: Services are provided in the community, but not in a homeless/emergency shelter, a faith-based location, home, the client's job site, a non-traditional service location, an age-specific community center, or school. Includes community centers that are not age-specific, non-residential substance-abuse treatment centers etc.

P = Phone

Definition: Services are provided by telephone contact, not involving video conferencing.

R = Residential Care – Children

Definition: Services are provided in a location supplying 24-hr non-medical care for children, other than inpatient hospital, or psychiatric health facilities (PHFs). Includes Community Treatment Facilities (CTFs) and family foster homes.

Definition of Community Treatment Facility (CTF): Any residential facility that provides mental health treatment services to children in a group setting, which has the capacity to provide secure containment.

S = School

Definition: Services are provided in any facility that has the primary purpose of education.

T = Telehealth

Definition: Also known as "Telemedicine." Services are provided so that the clinician and client are in two different locations but can see each other via visual equipment (e.g., video camera, web camera).

U = Unknown / Not Reported

Other terms for the glossary:

Community Treatment Facility (CTF): Any residential facility that provides mental health treatment services to children in a group setting, which has the capacity to provide secure containment.

Institute for Mental Disease (IMD): A term used by the Federal Government in California to distinguish skilled nursing facilities (SNF) that primarily care for people with psychiatric diagnoses, from those that provide care for people with primarily medical illnesses. Any SNF with greater than 16 beds and with 51% or more of its population with a psychiatric diagnosis is considered to be an IMD.

Mental Health Rehabilitation Center (MHRC): This is a 24-hour program, licensed by the State DMH, which provides intensive support and rehabilitation services designed to assist persons 18 years or older, with mental disorders who would have been placed in a state hospital or another mental health facility to develop skills to become self-sufficient and capable of increasing levels of independent functioning.

Psychiatric Health Facility (PHF): A non-hospital 24-hour acute care facility licensed by the DMH.

Skilled Nursing Facility (SNF): A health facility, which provides the following basic medical services: skilled nursing care and supportive care to clients whose primary need is for availability of skilled nursing care on an extended basis.

APPENDIX C

CSI DICTIONARIES FOR EVIDENCE-BASED PRACTICES/SERVICE STRATEGIES

Evidence-Based Practices (EBP) are "Program/services delivered in a culturally-competent manner that incorporates practices with generally accepted scientific fidelity, and that measure the impact of the practice on clients, participants and/or communities." There are over 100 EBP in the mental health field. The Federal government has chosen to collect data on 11 EBP. The Federal government developed the EBP dictionary. Santa Clara County Mental Health Department has added six additional EBP's that are being used throughout our County. There is a dictionary for these six.

Service Strategies (SS) are "Services and supports that incorporate the vision of the Mental Health Services Act (MHSA), as determined by multi-stakeholder input and participation." DMH developed 12 Service Strategies for providers to choose from. A provider can choose the Unknown category if they decide that no EBP or SS was used.

CSI DATA DICTIONARY

DEFINITIONS:

Evidence-Based Practices:
Programs/services delivered in a culturally-competent manner that incorporate practices with generally accepted scientific fidelity, and that measure the impact of the practice on clients, participants and/or communities. These evidence-based practices are more fully described by the Substance Abuse and Mental Health Services Administration (SAMHSA), and are available at http://www.nri-inc.org/CMHQA.cfm. Toolkits for some of the evidence-based practices are available at http://www.mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/.

Assertive Community Treatment (01)	A team-based approach to the provision of treatment, rehabilitation, and support services. Core components include: • Small caseloads • Team approach • Full responsibility for treatment services • Community-based services • Assertive engagement mechanisms • Role of consumers and/or family members on treatment team
Supportive Employment (02)	Services that promote rehabilitation and a return to productive employment for persons with serious mental illness. Core components include: • Vocational services staff • Integration of rehabilitation with mental health treatment • No exclusion criteria • Rapid search for competitive jobs • Jobs as transition • Follow-along supports
Supportive Housing (03)	Services to assist individuals in finding and maintaining appropriate housing arrangements and independent living situations. Criteria include: • Housing choice • Functional separation of housing from service provision • Affordability • Integration (with persons who do not have mental illness) • The right to tenure • Service choice • Service individualization • Service availability
Family Psychoeducation (04)	Offered as part of an overall clinical treatment plan for individuals with mental illness to achieve the best possible outcome through active involvement of family members in treatment and management. Core components include: • Family Intervention Coordinator • Quality of clinician-family alliance • Education curriculum • Structured problem-solving technique

CSI DATA DICTIONARY

DEFINITIONS:

Evidence-Based Practices *(continued)*

Integrated Dual Diagnosis Treatment (05)	Treatments that combine or integrate mental health and substance abuse interventions at the level of the clinical encounter. Core components include: • Multidisciplinary team • Stage-wise interventions • Substance abuse counseling • Outreach and secondary interventions
Illness Management and Recovery (06)	A practice that includes a broad range of health, lifestyle, self-assessment and management behaviors by the client, with the assistance and support of others. Core components include: • Comprehensiveness of the curriculum • Illness Management Recovery goal setting • Cognitive-behavioral techniques • Relapse prevention training
Medication Management (07)	A systematic approach to medication management for severe mental illnesses that includes the involvement of consumers, families, supporters, and practitioners in the decision-making process. Includes monitoring and recording of information about medication results. Critical elements include: • Utilization of a systemic plan for medication management • Objective measures of outcome are produced • Documentation is thorough and clear • Consumers/family and practitioners share in the decision-making
New Generation Medications (08)	A practice that tracks adults with a primary diagnosis of schizophrenia who received atypical second generation medications (including Clozapine) during the reporting year.
Therapeutic Foster Care (09)	Services for children within private homes of trained families. The approach combines the normalizing influence of family-based care with specialized treatment interventions, thereby creating a therapeutic environment in the context of a nurturant family home.
Multisystemic Therapy (10)	A practice that views the individual as nestled within a complex network of interconnected systems (family, school, peers). The goal is to facilitate and promote individual change in this natural environment. The caregiver(s) is viewed as the key to long-term outcomes.
Functional Family Therapy (11)	A program designed to enhance protective factors and reduce risk by working with both the youth and their family. Phases of the program are engagement, motivation, assessment, behavior change, and generalization.

SANTA CLARA COUNTY EVIDENCE-BASED PRACTICES

Aggression Replacement Therapy/Training

Aggression Replacement Training® (ART®) is a multimodal psychoeducational intervention designed to alter the behavior of chronically aggressive adolescents and young children. The goal of ART® is to improve social skill competence, anger control, and moral reasoning. The program incorporates three specific interventions: skill-streaming, anger-control training, and training in moral reasoning.

Brief Strategic Family Therapy (BSFT)

A short-term, problem-focused therapeutic intervention, targeting children and adolescents 6 to 17 years old, for the treatment of conduct problems, associations with antisocial peers, early drug use and the accompanying maladaptive family interactions (relations), all of which are recognized risk factors for substance abuse.

Cognitive Behavioral Therapy (CBT)

Teaches new responses or behaviors to replace behaviors which have become problematic in one's life. These behaviors may have been learned as a response to trauma or exposure to other psychologically harmful factors, but as the individual's environment changes these responses have become maladaptive. CBT is concerned with helping the client define problems cognitively as well as behaviorally and with promoting cognitive, emotional and behavioral change and preventing relapse. CBT is:

- time-limited
- structured, directive and problem-oriented
- is based on an educational model
- homework is a central feature

Incredible Years

Provides three comprehensive, multi-faceted and developmentally based curricula for parents, teachers, and children. The program is designed to promote emotional and social competence and to prevent, reduce, and treat aggressive, defiant, oppositional, and impulsive behaviors in young children 2 to 8 years old.

Motivational Interviewing

A directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence. Compared with nondirective counseling, it is more focused and goal-directed. The examination and resolution of ambivalence is its central purpose, and the counselor is intentionally directive in pursuing this goal.

Parent-Child Interaction Therapy (PCIT)

An evidence-based treatment model with highly specified, step-by-step, live-coached sessions with both the parent/caregiver and the child. Parents learn skills through PCIT didactic sessions, and, using a transmitter and receiver system, the parent/caregiver is coached in specific skills as he or she interacts in specific play with the child. Generally, the therapist provides the coaching from behind a one-way mirror or from observing on a video monitor. The emphasis is on changing negative parent/caregiver child patterns.

CSI DATA DICTIONARY

DEFINITIONS:

Service Strategies:
Services and supports that incorporate the vision of the Mental Health Services Act (MHSA), as determined by multi-stakeholder input and participation. The broad categories listed below are designed to describe county services or programs with respect to a common concept or underlying strategy. Therefore, counties may implement different kinds of programs/services with a similar underlying strategy, all of which would be coded under the same Service Strategy in CSI - per the broad definitions below. The Service Strategies data element is designed to be a modifier to the service function codes, in order that more specific information about services/supports may be known for reporting purposes. The Service Strategies data element is to be collected and reported for all service function codes reported to CSI, regardless of whether or not the service/program is part of MHSA implementation.

Peer and/or Family Delivered Services (50)	Services and supports provided by clients and family members who have been hired as treatment program staff, or who provide adjunct supportive or administrative services, such as training, information dissemination and referral, support groups and self-help support and empowerment. Please note that if the service/support is to be reimbursed by Medi-Cal, client and family member staff duties and credentials must meet Medi-Cal provider certification requirements.
Psychoeducation (51)	Services that provide education about: • Mental health diagnosis and assessment • Medications • Services and support planning • Treatment modalities • Other information related to mental health services and needs
Family Support (52)	Services provided to a client's family member(s) in order to help support the client.
Supportive Education (53)	Services that support the client toward achieving educational goals with the ultimate aim of productive work and self-support.

DEFINITIONS:

Service Strategies *(continued)*

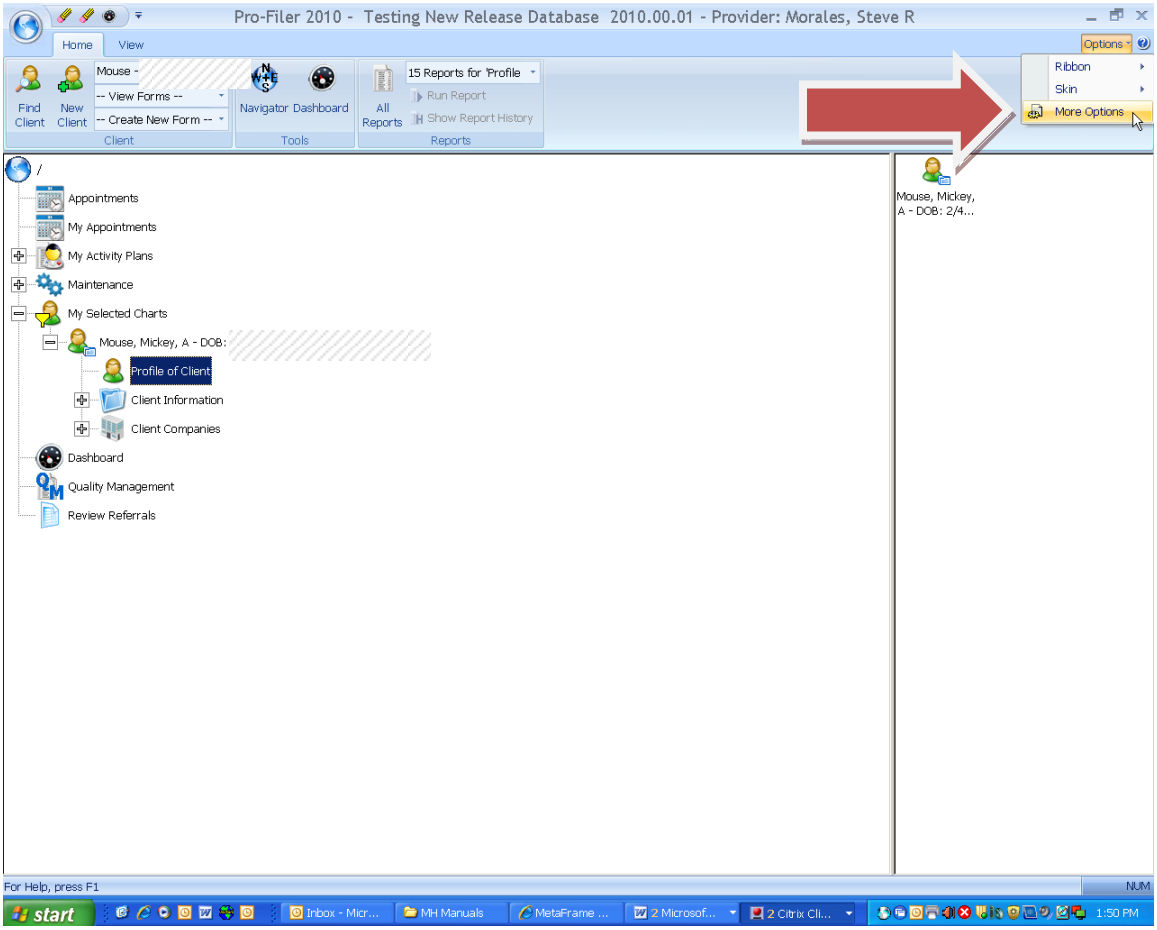
Delivered in Partnership with Law Enforcement (includes courts, probation, etc.) (54)	Services that are integrated, interdisciplinary and/or coordinated with law enforcement, probation or courts (e.g., mental health courts, jail diversion programs, etc.) for the purpose of providing alternatives to incarceration/detention for those with mental illness/emotional disturbance and criminal justice system involvement.
Delivered in Partnership with Health Care (55)	Integrated, interdisciplinary and/or coordinated physical and mental health services, including co-location and/or collaboration between mental health and primary care providers, and/or other health care sites.
Delivered in Partnership with Social Services (56)	Integrated, interdisciplinary and/or coordinated social services and mental health services, including co-location and/or collaboration between mental health and social services providers.
Delivered in Partnership with Substance Abuse Services (57)	Integrated, interdisciplinary and/or coordinated substance use services and mental health services, including co-location and/or collaboration between mental health providers and agencies/providers of substance use services. This strategy is distinguished from the Federal evidence-based practice, "Integrated Dual Diagnosis Treatment", in that for this strategy the integration does not need to occur at the level of the clinical encounter.
Integrated Services for Mental Health and Aging (58)	Integrated, interdisciplinary and/or coordinated services for mental health and issues related to aging, including co-location and/or collaboration between mental health providers and agencies/providers of services specific to aging (e.g., health, social, community service providers, etc).
Integrated Services for Mental Health and Developmental Disability (59)	Integrated, interdisciplinary and/or coordinated mental health services and services for developmental disabilities, including co-location and/or collaboration between mental health providers and agencies/providers of services specific to developmental disabilities.
Ethnic-Specific Service Strategy (60)	Culturally appropriate services that reach and are tailored to persons of diverse cultures in order to eliminate disparities. Includes ethnic-specific strategies and community cultural practices such as traditional practitioners, natural healing practices, and ceremonies recognized by communities in place of, or in addition to, mainstream services.
Age-Specific Service Strategy (61)	Age-appropriate services that reach and are tailored to specific age groups in order to eliminate disparities. Age-specific strategies should promote a wellness philosophy including the concepts of both recovery and resiliency.

APPENDIX D

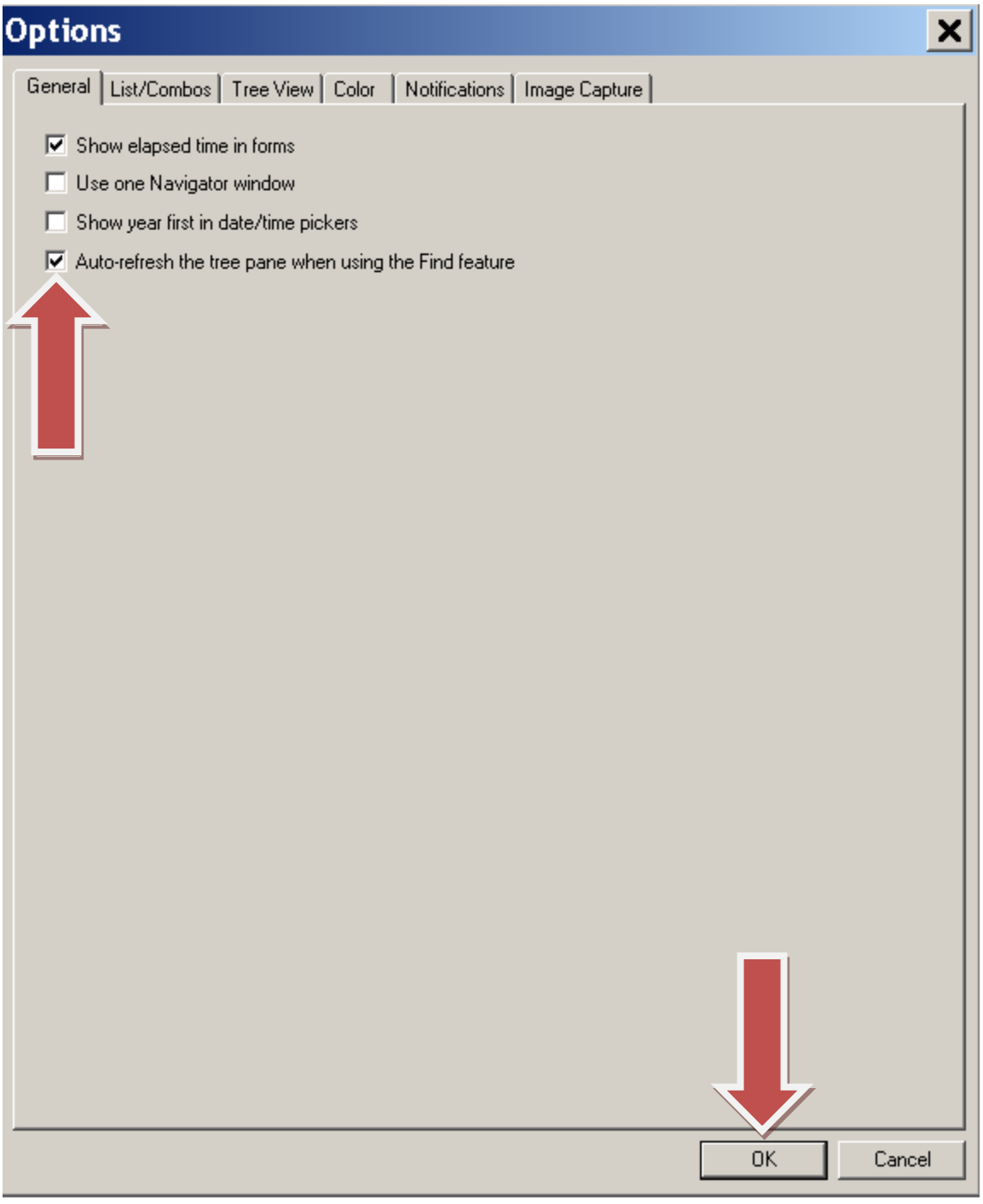
ENABLING AUTO REFRESH FROM THE TREE VIEW

This is an option that is recommended for all providers. If you perform the following process, you will not have to right-click on My Selected Charts and select Refresh. The client name will automatically show itself on the Tree View.

Click the **Options** button and choose **More Options**.



Click the Auto Refresh box then click **OK**. If you can't see the OK button, just press Enter on your keyboard.



APPENDIX E

VOIDS, POLICIES AND PROCEDURES, SECTION 635

The Void forms can be found in the Behavior Health Systems homepage. This is the first screen you see after you click on the Unicare globe from your desktop.

1. On the right-hand side, click Mental Health under the Updates heading.
2. Click MH Forms (PC Users) for County clinics or MH Forms (Thin Client Users) for Contractor agencies.
3. Choose Voiding Services for either PBS Form or the IS Form
4. Print the form, fill it out and fax it to the appropriate department.

_____
Mental Health Director

SUBJECT: **SERVICE ITEM VOIDING/DELETION – UNICARE AND DIAMOND**

ENCLOSURES: None

REFERENCE: N/A

POLICY:

This policy pertains to both the Unicare and Diamond data systems. A service that has been recorded in Unicare is identified for deletion by checking a "Void" button. In Diamond, the deletion process uses a "Deletion" function.

Before the end of the 5th Day of Subsequent Month: A service performed in a particular month may be voided (deleted) before the end of the 5th day of the subsequent month. (For example: a service performed on January 10th, and recorded on January 11th, can be voided up to the end of February 5th.) In this case, the Contractor or County staff person may then re-enter the correct service.

After 5th Day of Subsequent Month: A service performed in a particular month and then voided (deleted) after the end of the 5th day of the subsequent month, may be re-entered under certain circumstances. (For example: a service performed on January 10th, and recorded on January 11th, and then voided on February 6th may have already been billed to a third party and thus will require special review before being re-entered.). In this case, PBS may have to refund a payment from a third party payor for the incorrectly entered service.. If no billing to a third party has occurred then the correct service can be entered. In certain specific situations, if the service has been billed to a third party, a corrected service may not be re-entered into Unicare. In this case, the process of reconciling units of service will take place in the year end cost report. Re-entering services to correct voided (deleted) claimed services that

have already been billed to a third party may cause duplicate billing and is illegal.
POLICY (Cont.):

Note: This void process is separate from the State Department of Mental Health Disallow Claims System (DMH Information Notice 05-05), which requires specific procedures to be followed. This Disallow process is designed to eliminate certain services from audit review only.

PROCEDURE:

I. UNICARE

Responsible Party	**Action**
County Staff S/D Contractors	**Before end of 5th Day of Subsequent Month (SM):** ▪ May void a service as necessary. ▪ May re-enter a corrected service as appropriate. **After 5th Day of SM:** ▪ May void a service as necessary. ▪ After voiding a service, staff can determine whether the service was billed to a third party or not by running report: BHS0005 Voided Services Claim ID v2. ▪ If the Unicare report indicates that the service has <u>not</u> been billed to a third party, then staff person may re-enter the corrected service. ▪ If the Unicare report indicates that the service has been billed to a third party, the service may be re-entered <u>only</u> under the following circumstances: a) Corrected service was performed on a different date from the erroneously entered date. b) Corrected service was a different service.

PROCEDURE (Cont.):

Responsible Party	Action
County Staff S/D Contractors	*Note:* County Clinicians/Physicians must **also** re-enter the progress note if a service is re-entered into Unicare and will printout another progress note report to sign and file. If the hardcopy chart includes a progress note associated with a voided service, this note should be crossed out per standard procedures.
PBS	Runs appropriate report (BHS0005 Voided Services Claim ID v2) to identify voided services. Services that have already been billed to third party payors may require a refund.

II. DIAMOND

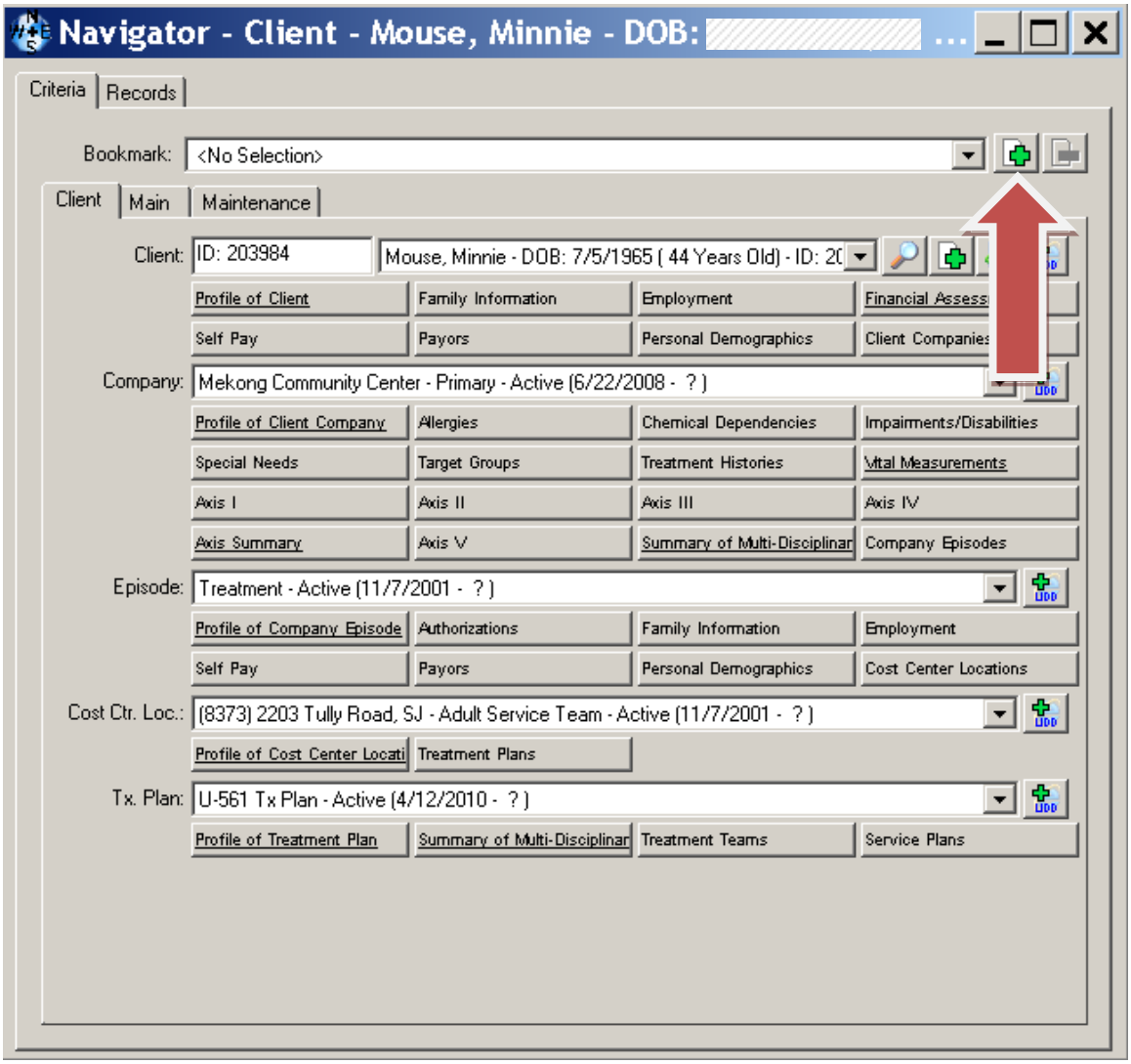
Responsible Party	Action
Claiming Department	Notifies the Department Manager or Diamond Software Administrator in writing of claim number to be deleted and reason for deletion.
Department Manager or Diamond Software Administrator	Deletes the service as indicated by Diamond procedures. If the services have a status of "F" or "P" (have completed the APUPD process), notify the Claiming Department to complete the procedures for adjusting the claim. Must inform PBS/Finance regarding deleted services so appropriate cost report adjustments can be made.

APPENDIX F

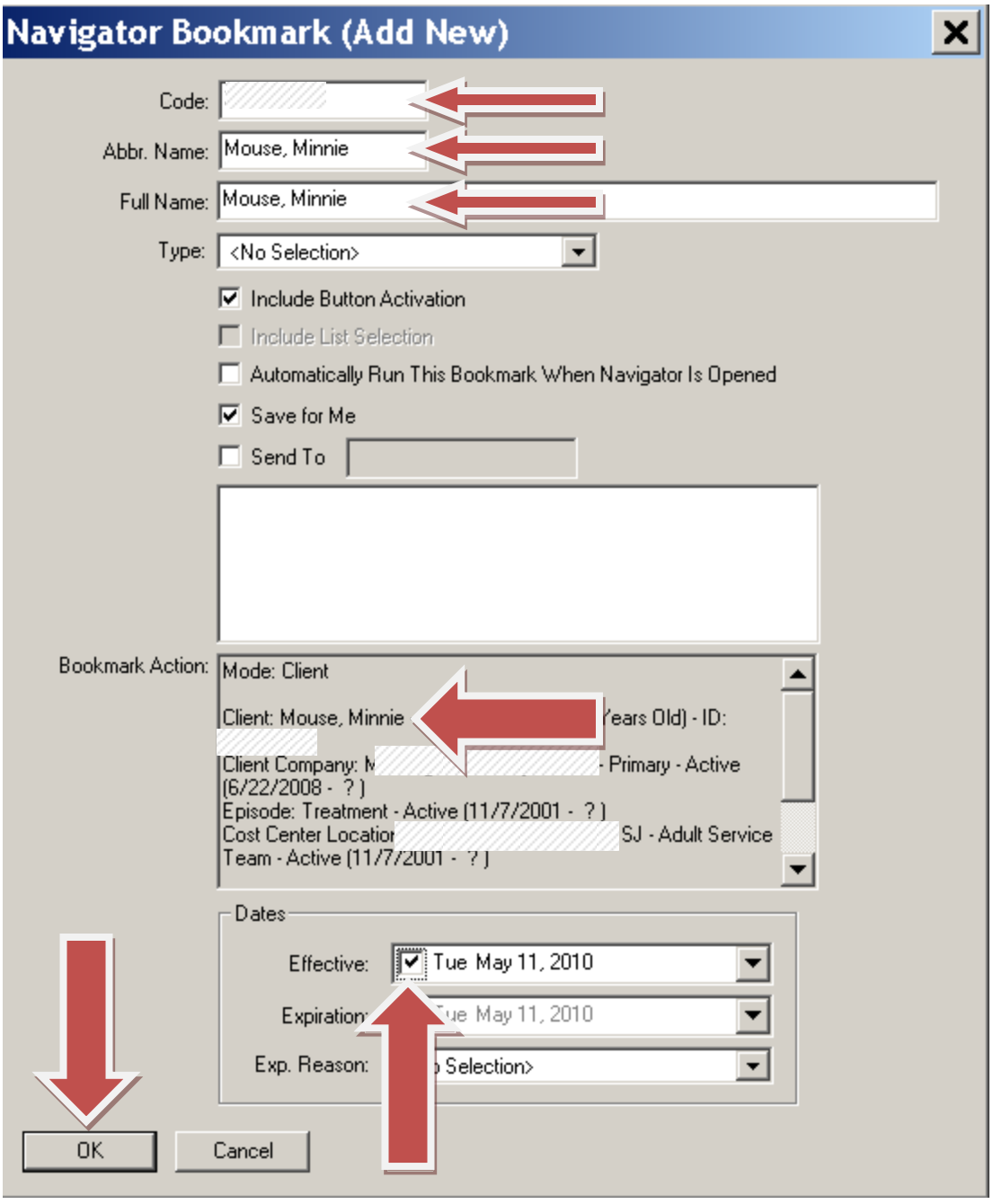
USING BOOKMARK IN NAVIGATOR

By using the Bookmark feature within Navigator, you will be able to develop a unique list of clients, making it easier to find clients, record services and look up past services. This is very helpful if you have an intern because you could store your intern's clients in here.

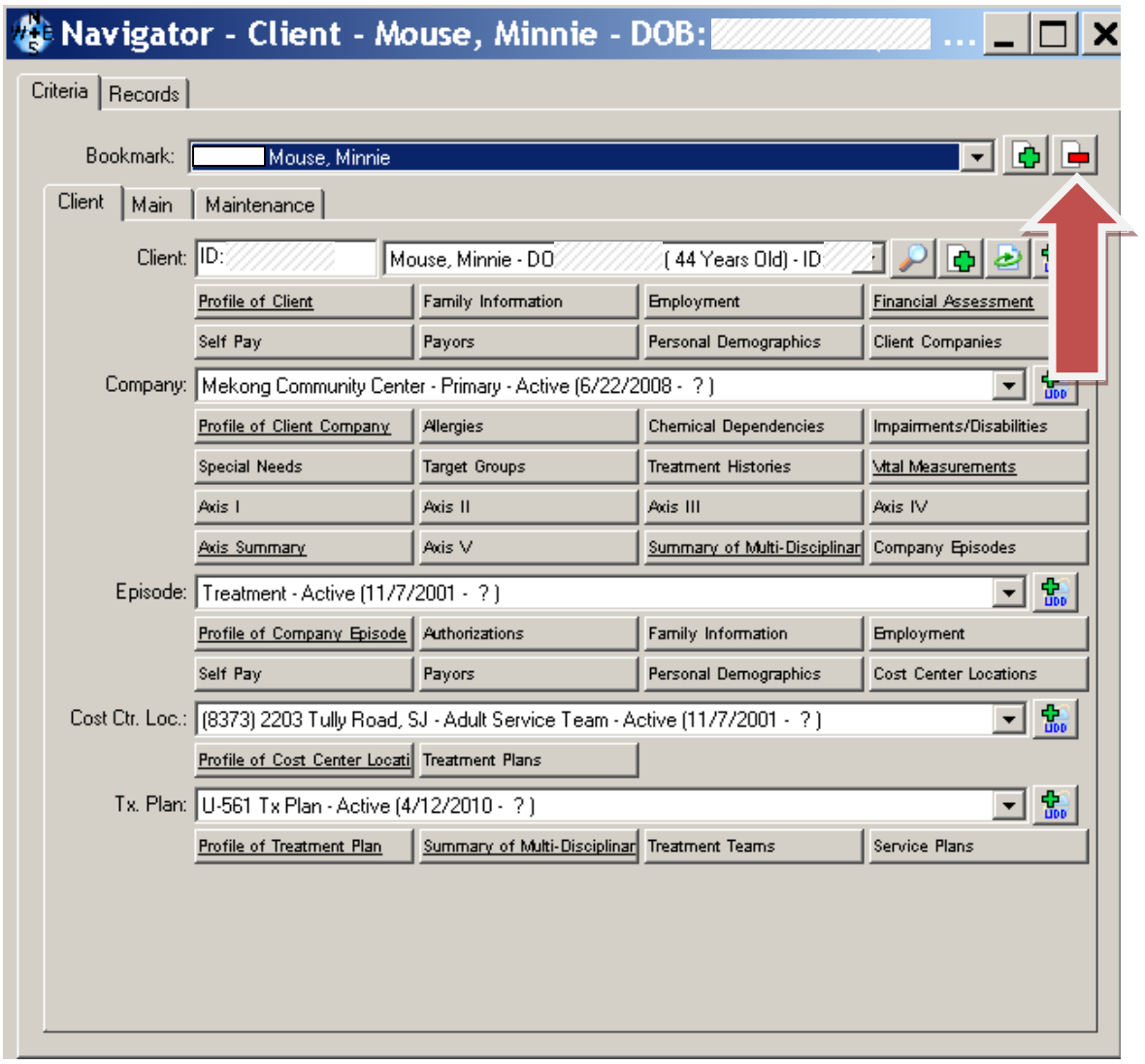
Do a search (see page 16) and when a client's data is filled in completely, click on the **Add New** icon (green plus sign).



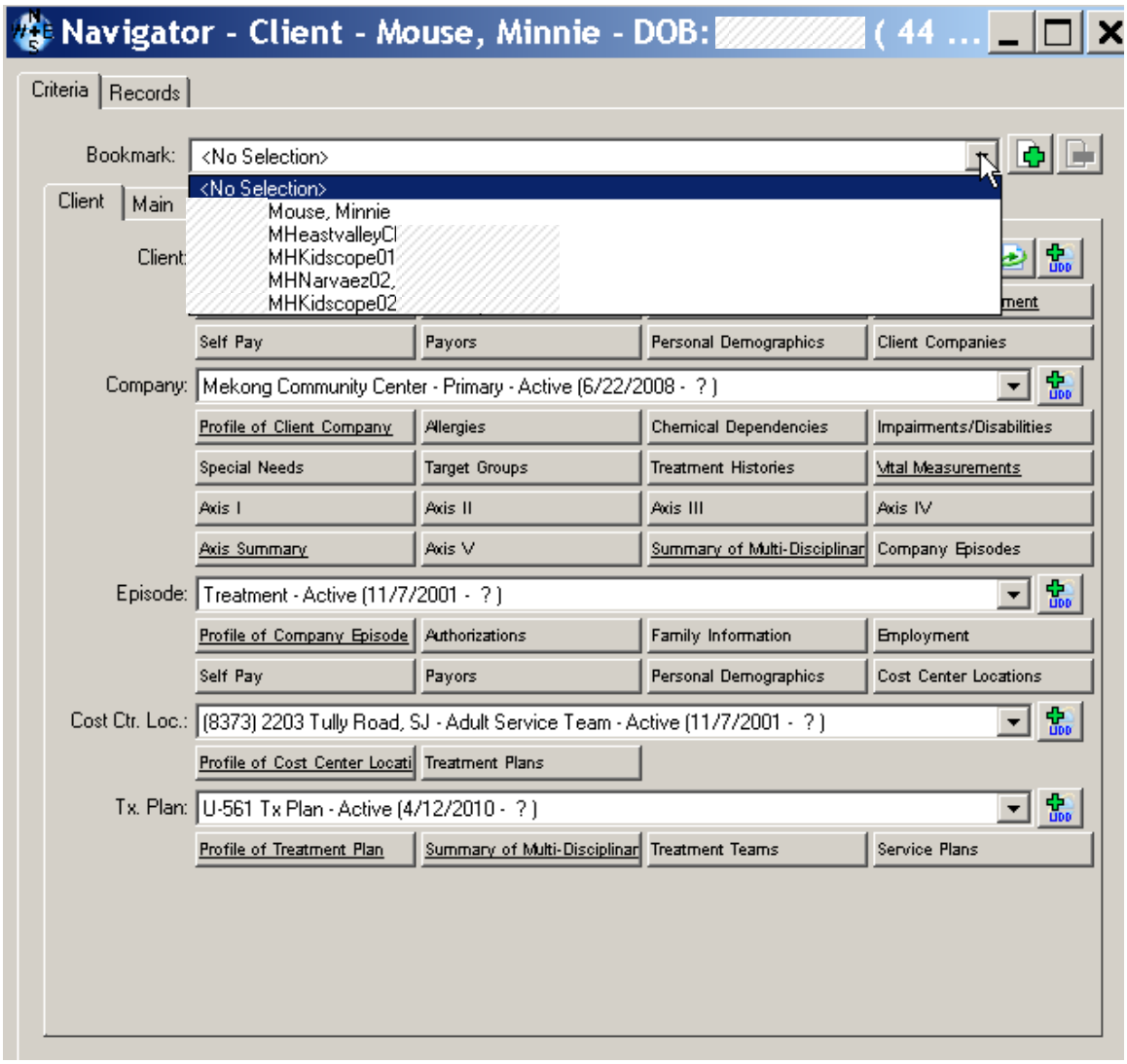
Copy and paste the client's Unicare ID from the Client info section into the **Code field.**
Copy and paste the client's name in both the **Abbr. Name** and the **Full Name** field.
Click the **Effective Date**.
Click **OK**



The client's ID and name are now in the Bookmark field and will remain there until you delete it by clicking on the **Delete** icon (red minus sign).



The next time you need to access this client's chart, click on the drop down menu and choose the name you need. The fields will automatically fill in.



APPENDIX G

FINDING A CLIENT FROM THE TREE VIEW

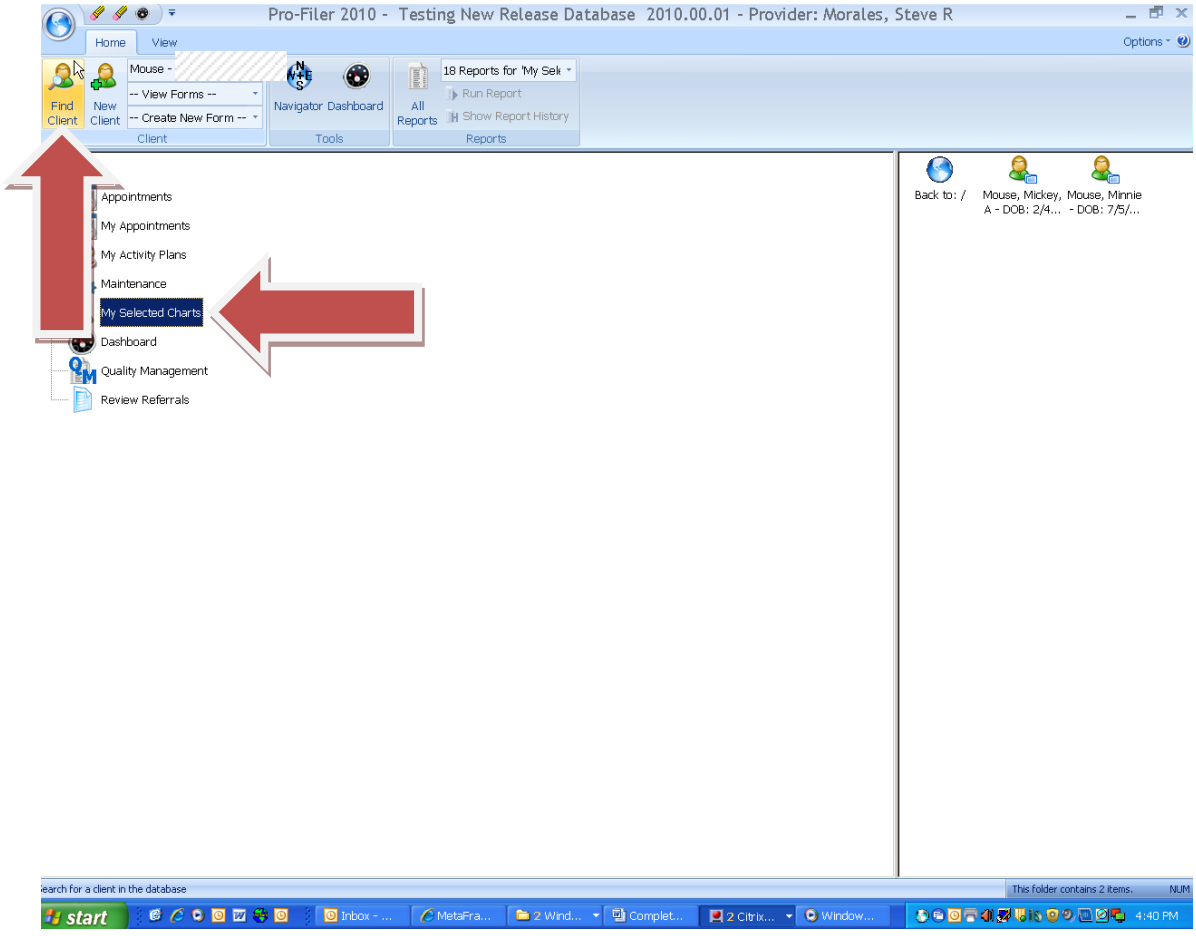
The screen shown below is called the Tree View or Tree. Begin here.

There are two methods for finding a client in Unicare:

Method 1 – Click the **Find Client** icon located at the top left-hand corner of the toolbar. Do not use the New Client icon.

Method 2 – Right click on **My Selected Charts** and select **Find**.

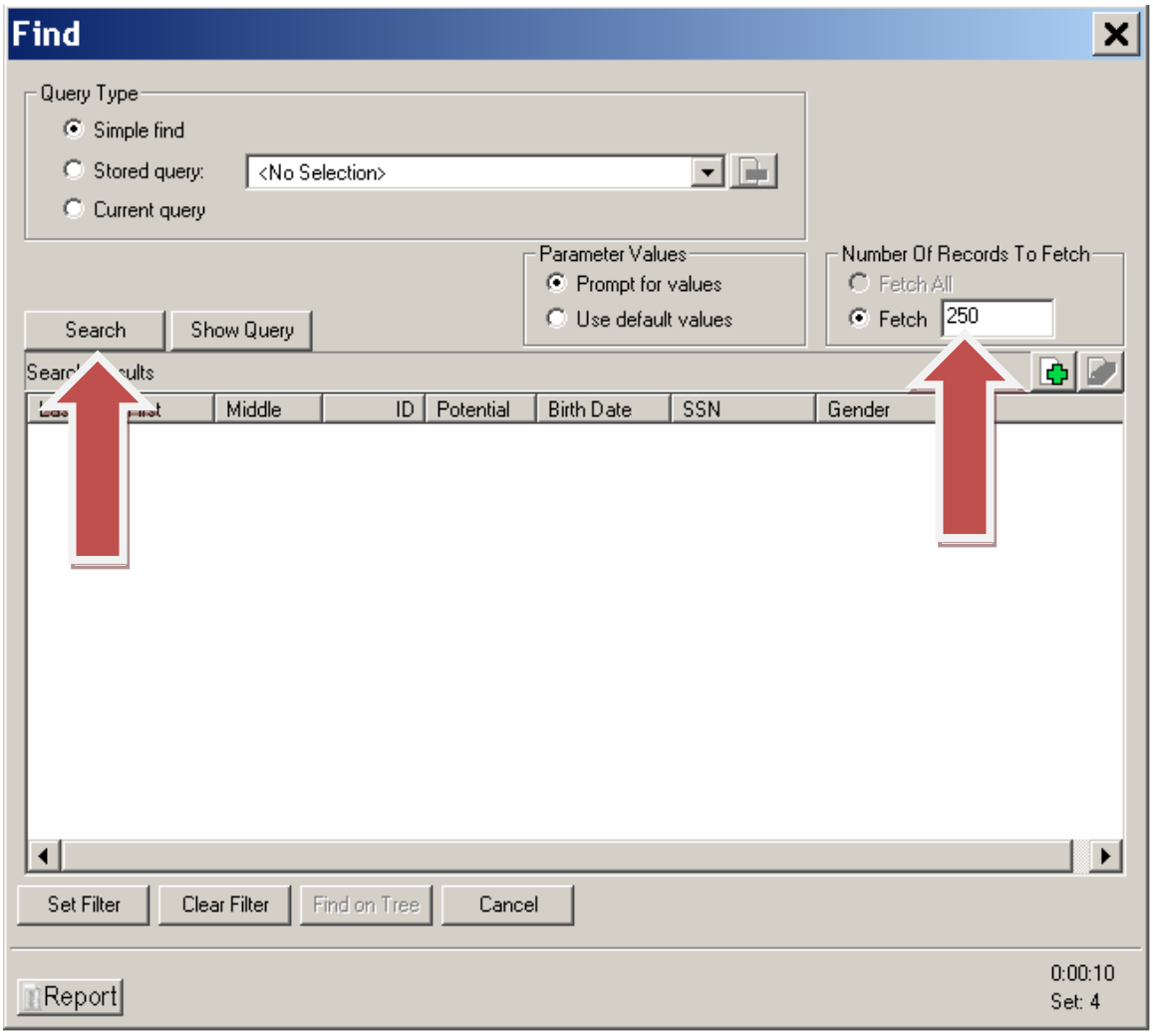
Both methods take you to the same Find screen.



The Find screen gives the provider three options on how to search for a client, Simple find, Stored query and Current query. We will look at Simple find for now.

Click **Search**.

Note: Fetch refers to the maximum number of records that the system will search for. The provider can adjust this number to narrow or widen the search.



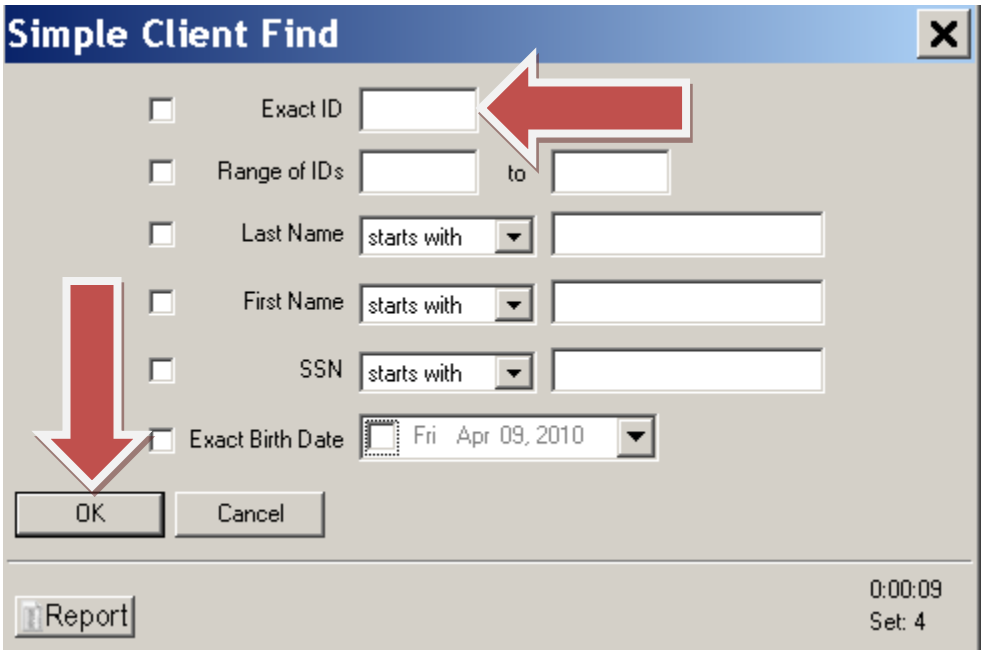
The following screen will be displayed.

The Simple Find query uses client information such as Exact ID, Last Name, First Name, Social Security Number (SSN) or Birth Date.

For existing clients, the simplest and most common search criterion is to use the Exact ID. Unicare is designed to assign only one ID per client. If you are certain that the client you are searching for has only one ID assigned to him/her, use the Exact ID field.

1. Type in the client's number.
2. Click **OK**.

Note: It is possible that a client could have multiple ID's due to misspelling of a name or transposing of a number in the Social Security Number (SSN). If you notice this, talk with your clerical staff to determine the correct ID.



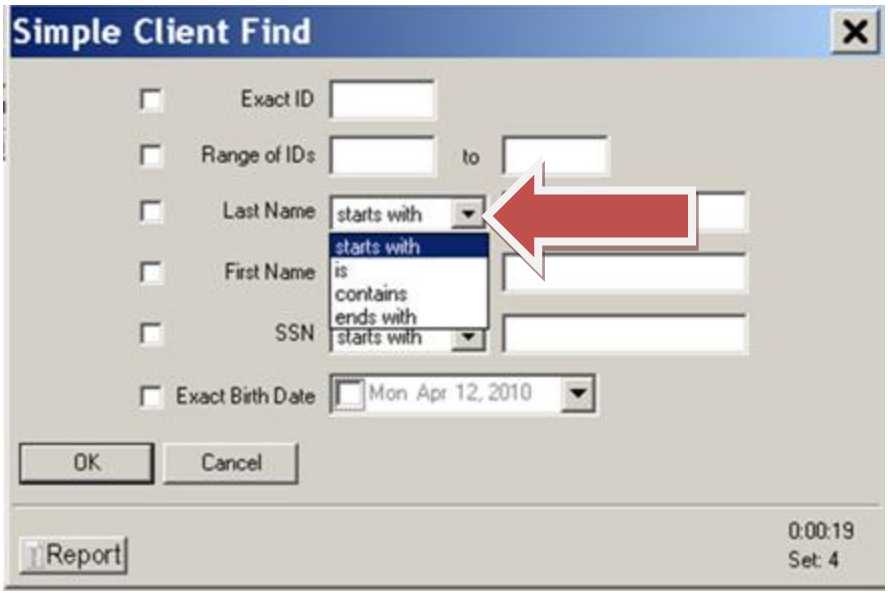
If you use the Last Name and/or First Name to find a client but you do not have the complete name, click on the drop down menu. You have four options to help you find your client.

1. starts with
2. is
3. contains
4. ends with

Note 1: Last Name and First Name are not case sensitive, so it does not matter if you capitalize the first letter.

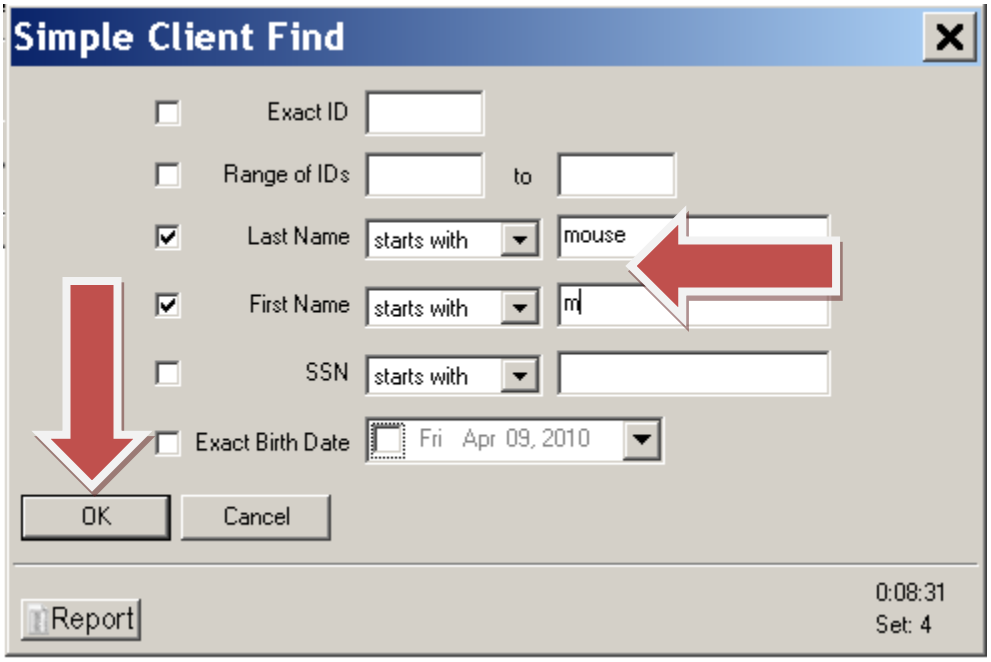
Note: If you use the SSN, you must type in the dashes, e.g., 123-45-6789

Note: You do not need to click on the radio buttons to the left of the data fields. They will automatically fill in.



For example, if you think the client's last name is mouse and the first name starts with m:

1. In the Last Name field type in mouse
2. In the First Name field type in m
3. Click **OK**

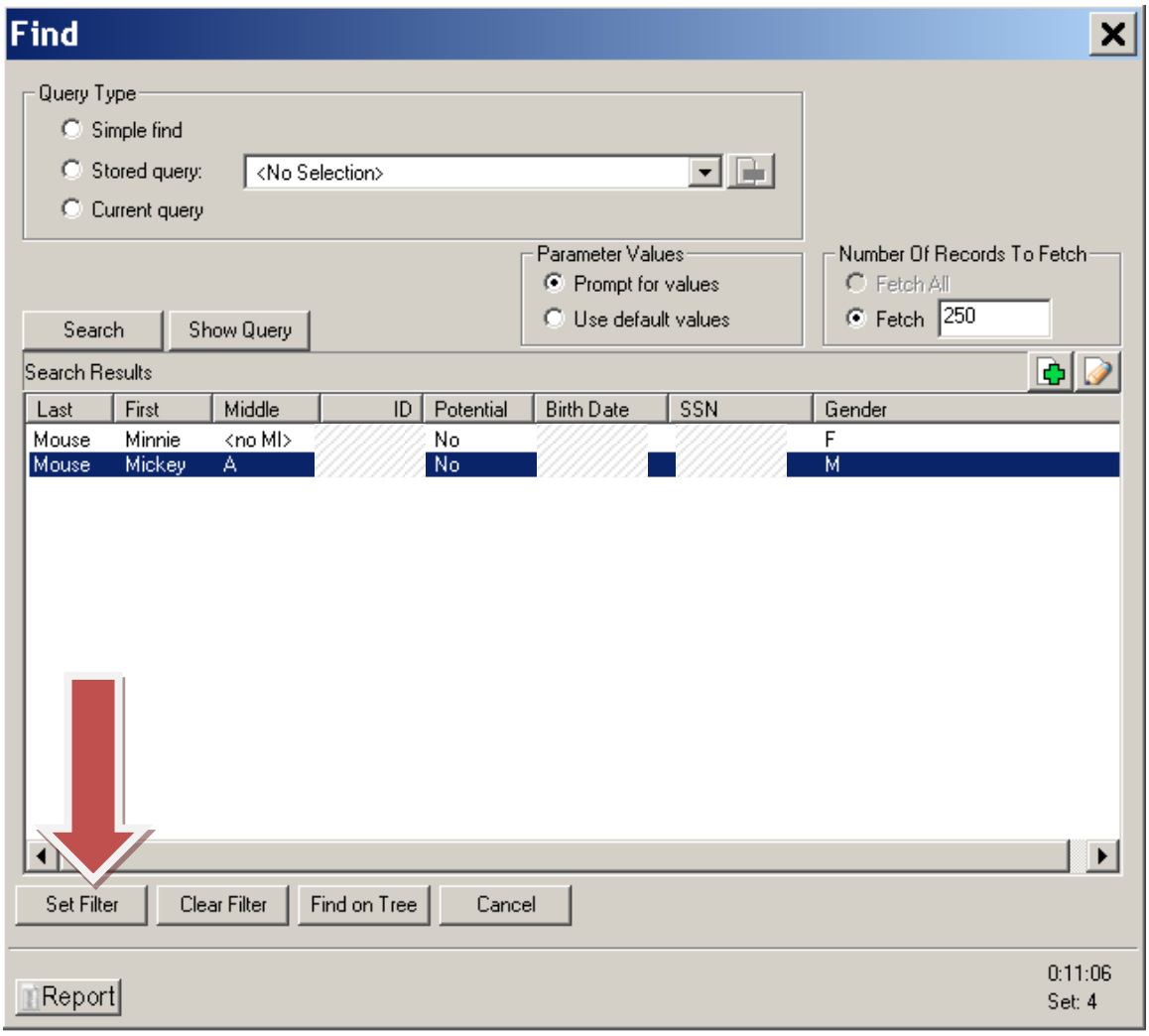


The following screen will be displayed.

.

If the client's name is the only one that appears, just click **Set Filter**. There is no need to highlight the name.

If you get more than one client, check other information such as birth date or SSN to help you choose the correct client. Highlight the correct name with only one click then click **Set Filter**.

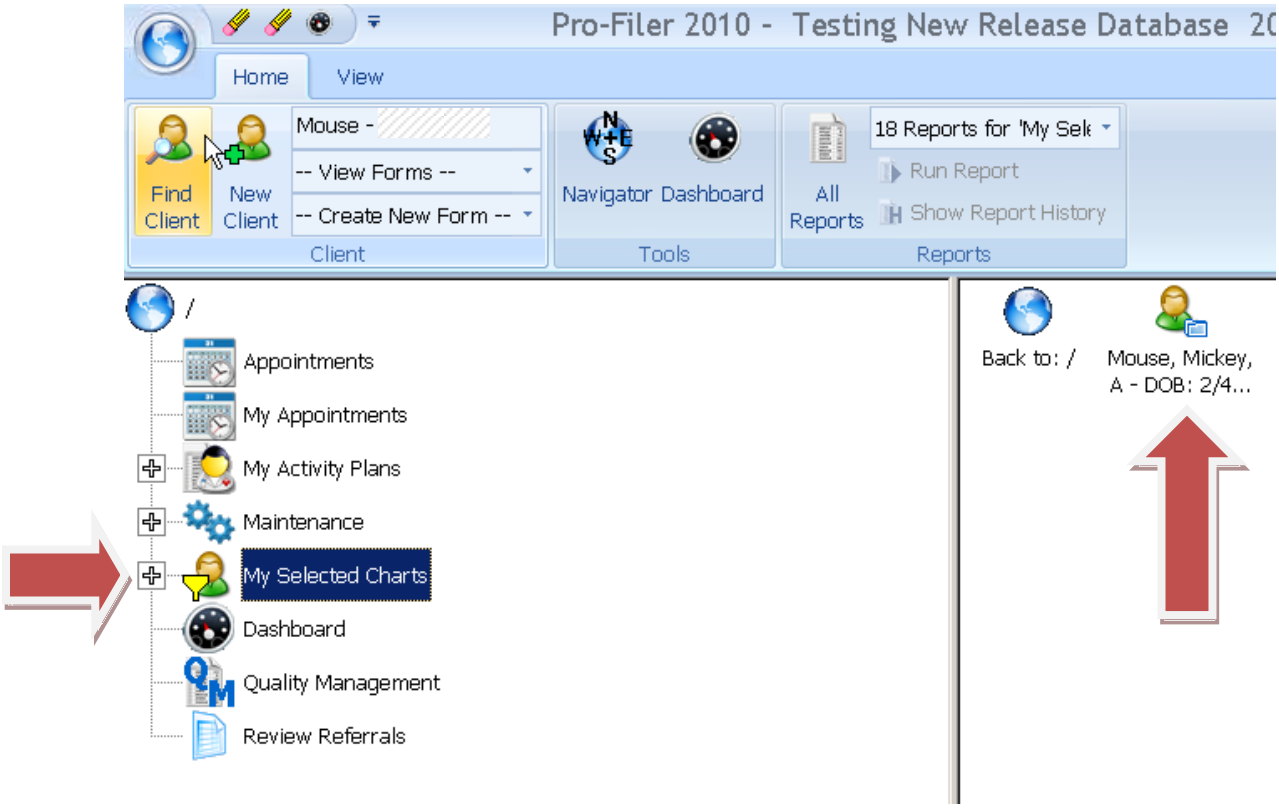


Clicking **Set Filter** will take you back to the Tree View

If you have Auto-Refresh set up, your client's name will appear on the right side of your screen. Click the plus sign once to the left of **My Selected Charts** and the client's name will appear.

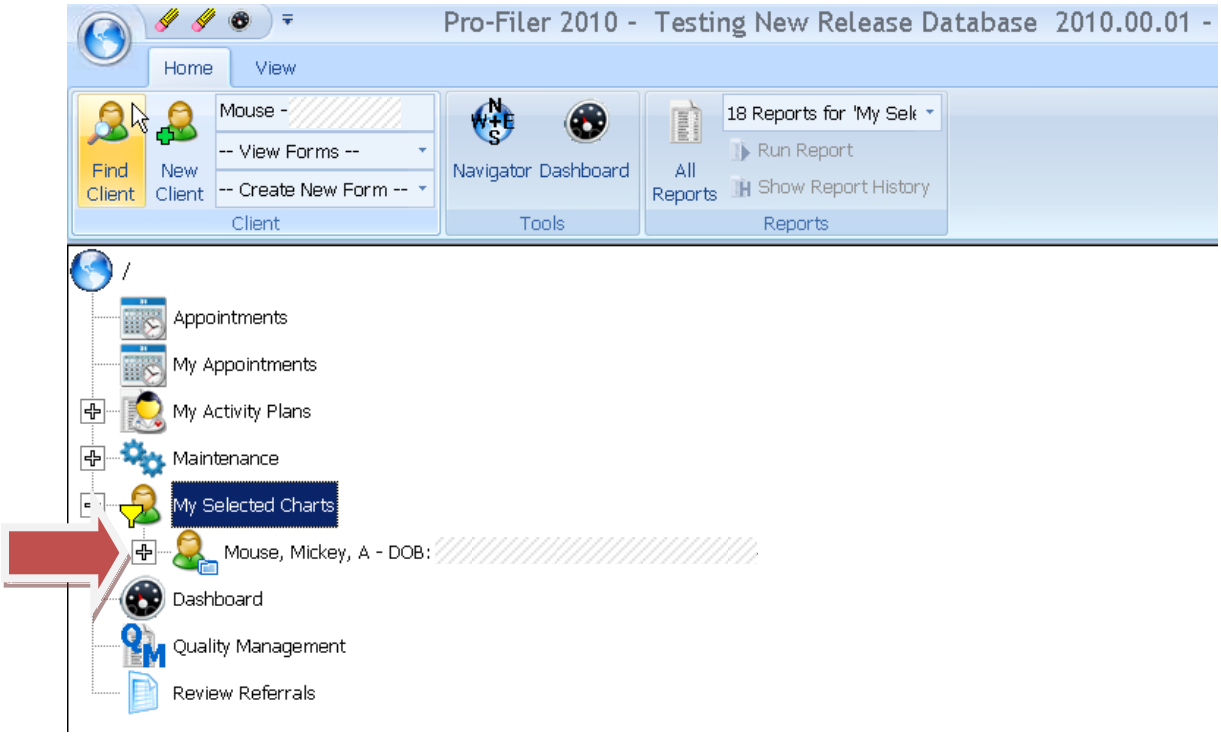
If you do not have Auto Refresh set up, right click on **My Selected Charts** and choose **Refresh**. Click the plus sign once to the left of **My Selected Charts**. The client's name will appear.

Please read Appendix D to learn how to set up Auto Refresh. This will save you time.



The following screen will appear.

The plus sign changes to a minus and the client's name appears with another plus sign to the left of the name. Click the plus sign to the left of the client's name. This will further expand the Tree View to show the **Profile of Client** and other folders.



APPENDIX H

RECORDING SERVICES FROM THE TREE VIEW

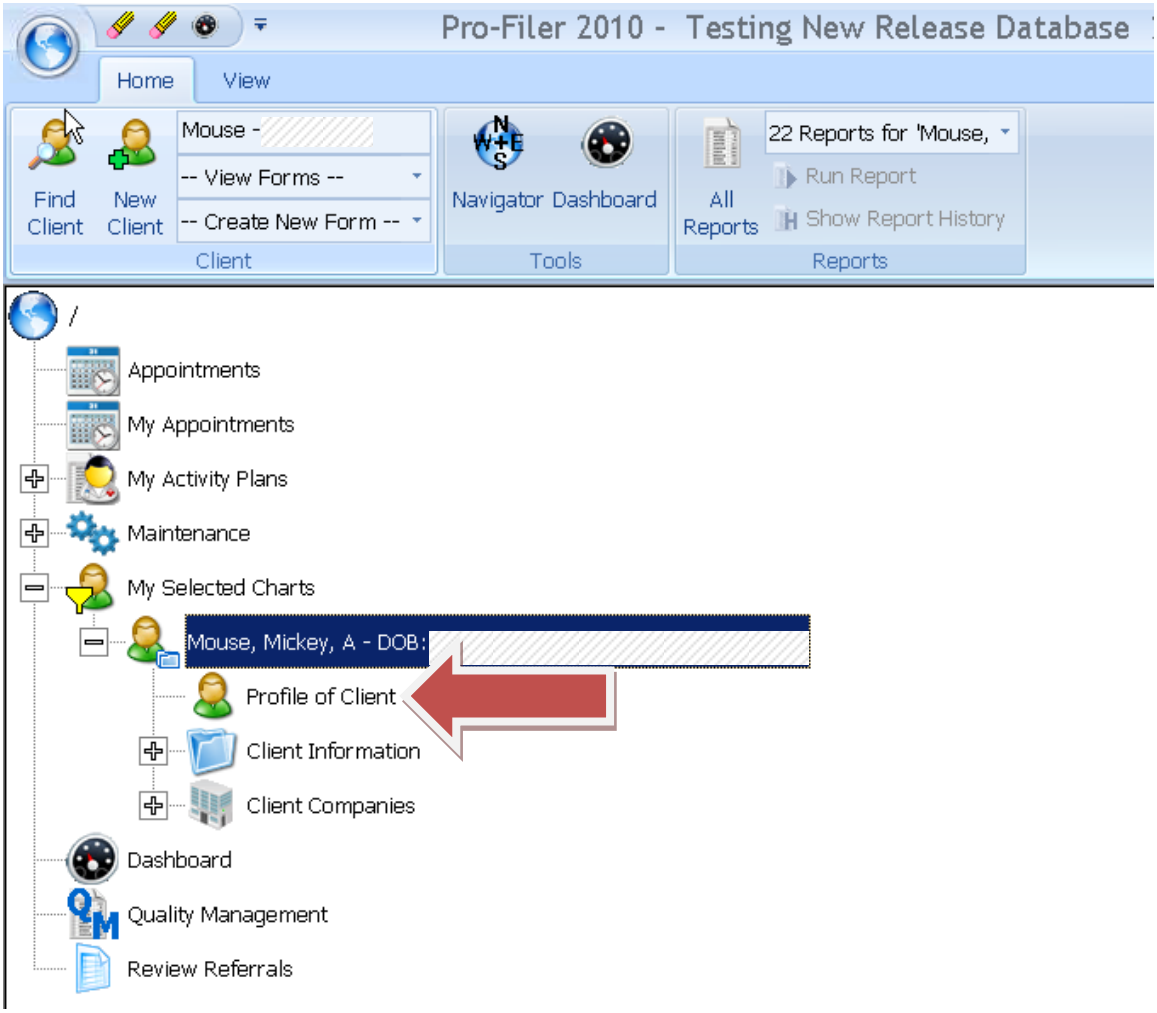
The **Profile of Client** folder is where a provider records a service, writes a progress note, records an evidence-based practice and/or service strategy, and writes initial or update assessments.

Double click on **Profile of Client**, or, if you prefer, right click and choose Open.

Note: You only need to double click two places when using Unicare:

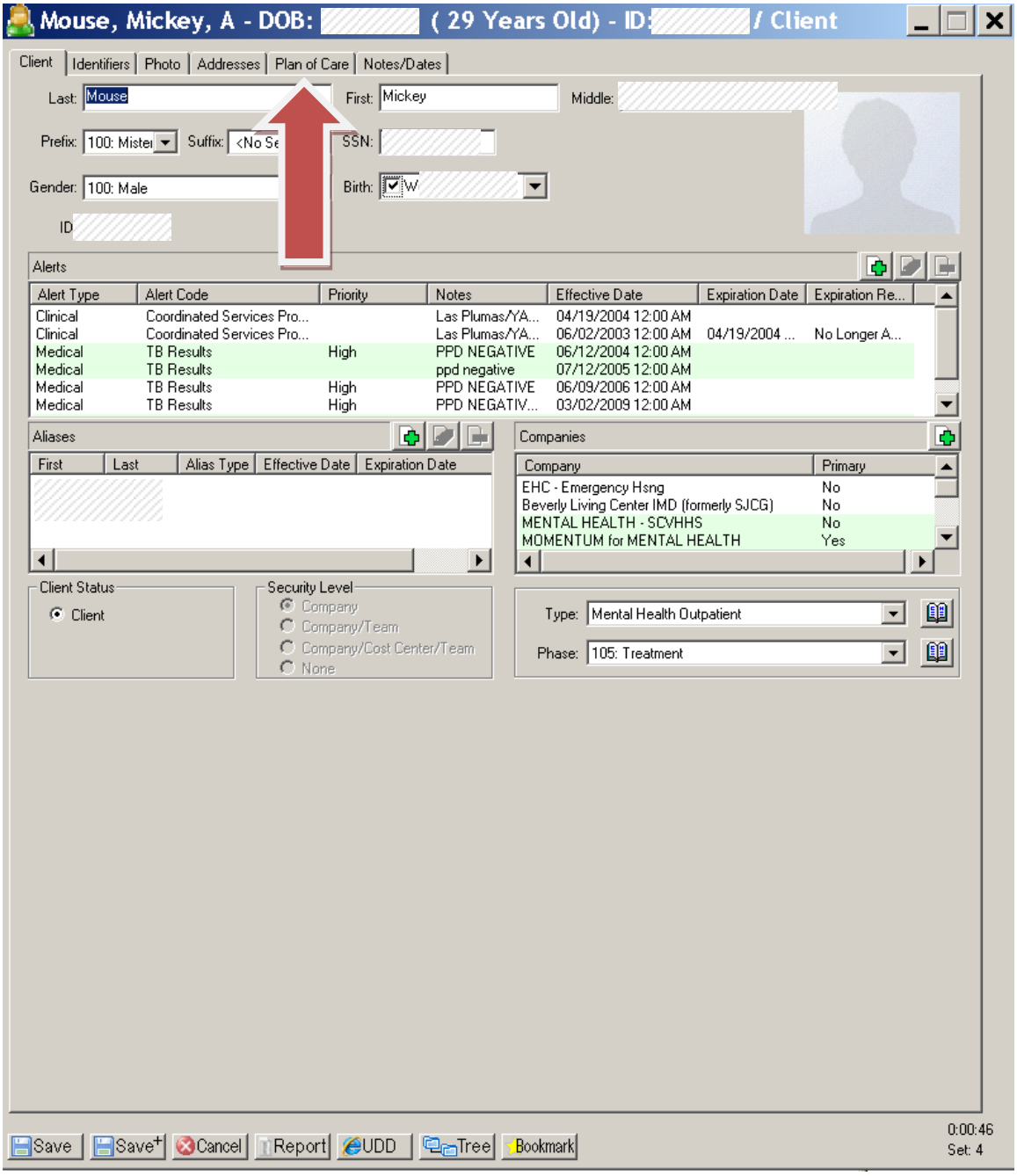
1. *At your desktop on the Unicare icon (world globe)*
2. *At the Profile of Client*

The other folders below Profile of Client are used by clerical staff.



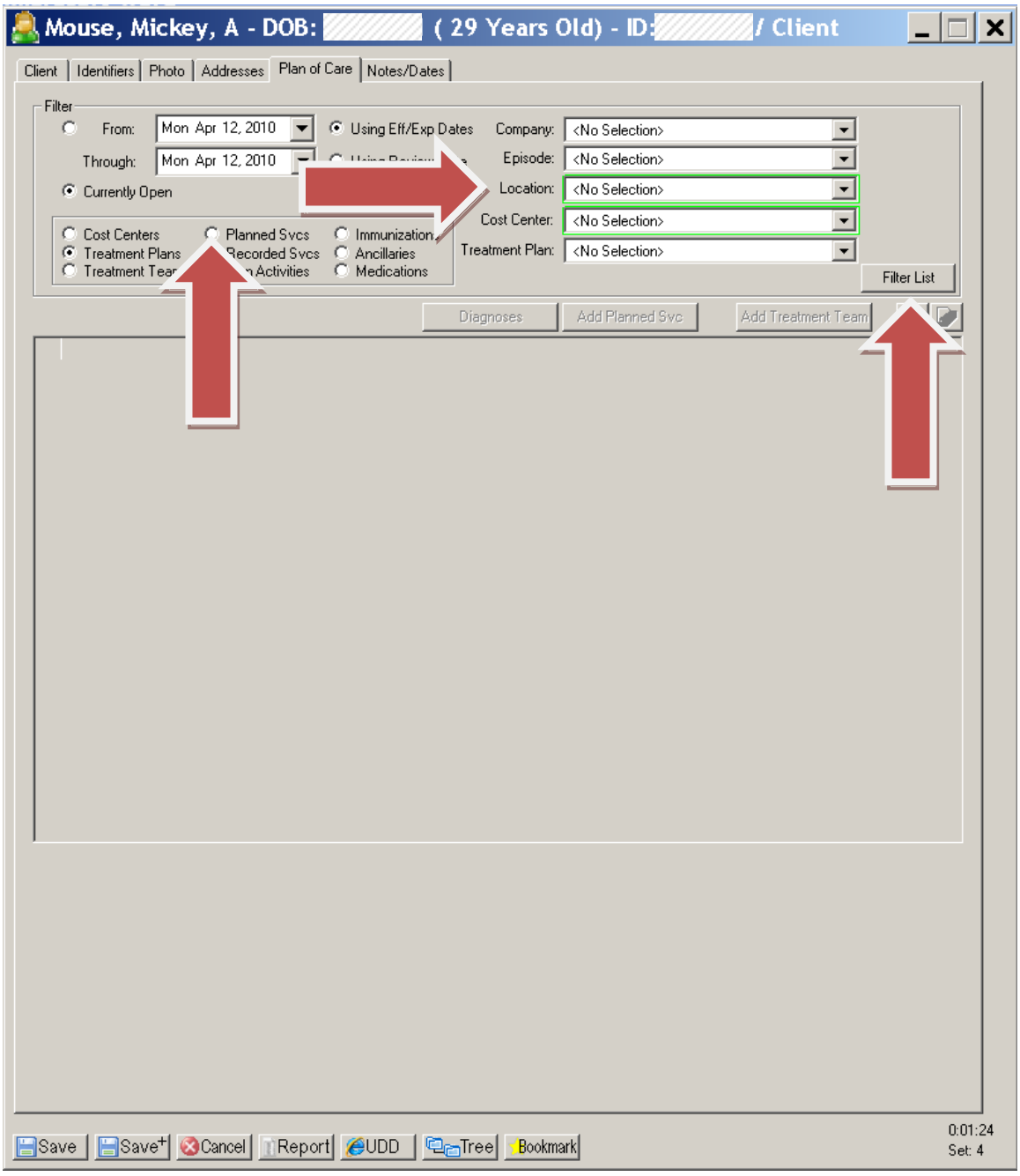
The Profile of Client screen defaults to the **Client** tab. This screen has some of the client's demographic information.

Click the **Plan of Care** tab.



The following screen will be displayed.

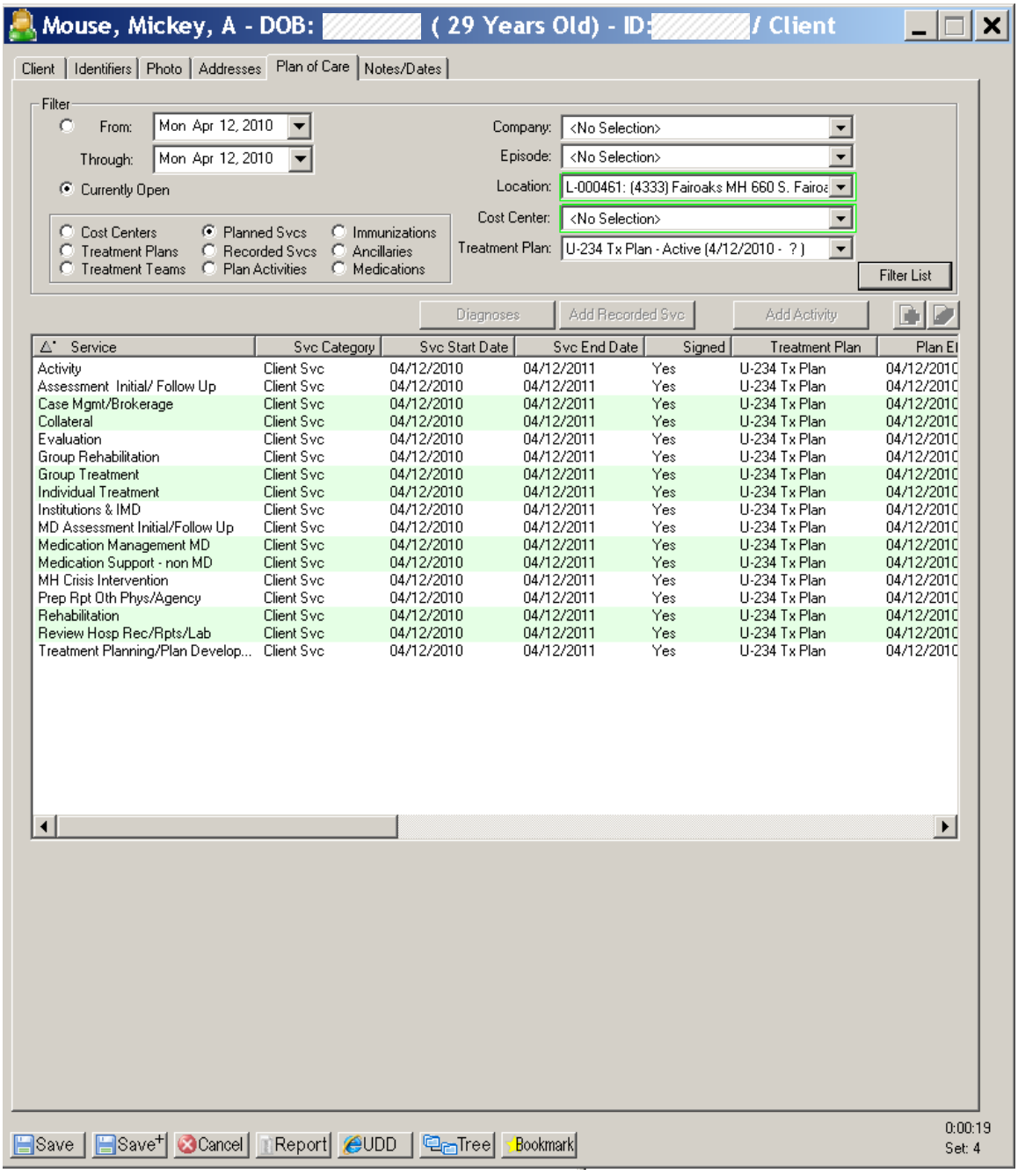
1. Click **Planned Svcs**.
2. Click the **Location** drop down and choose your clinic. Clients can be open to more than one clinic, e.g., Downtown, EPS, Urgent Care and Momentum.
3. Click **Filter List**.



The following screen will be displayed.

What appears is all of the Planned Services available for the provider to choose from.

Note: Notice the green stripes in the Planned Services field. They are only there to help a user read across a screen. You will see these green stripes in other fields.


Mouse, Mickey, A - DOB: (29 Years Old) - ID: / Client
Client
Identifiers
Photo
Addresses
Plan of Care
Notes/Dates
Filter
From: Mon Apr 12, 2010
Through: Mon Apr 12, 2010
Currently Open
Cost Centers
Treatment Plans
Treatment Teams
Planned Svcs
Recorded Svcs
Plan Activities
Immunizations
Ancillaries
Medications
Company: <No Selection>
Episode: <No Selection>
Location: L-000461: (4333) Fairoaks MH 660 S. Fairoa
Cost Center: <No Selection>
Treatment Plan: U-234 Tx Plan - Active (4/12/2010 - ?)
Filter List
Diagnoses
Add Recorded Svc
Add Activity
Service | Svc Category | Svc Start Date | Svc End Date | Signed | Treatment Plan | Plan E
Activity | Client Svc | 04/12/2010 | 04/12/2011 | Yes | U-234 Tx Plan | 04/12/201C
Assessment Initial/ Follow Up | Client Svc | 04/12/2010 | 04/12/2011 | Yes | U-234 Tx Plan | 04/12/201C
Case Mgmt/Brokerage | Client Svc | 04/12/2010 | 04/12/2011 | Yes | U-234 Tx Plan | 04/12/201C
Collateral | Client Svc | 04/12/2010 | 04/12/2011 | Yes | U-234 Tx Plan | 04/12/201C
Evaluation | Client Svc | 04/12/2010 | 04/12/2011 | Yes | U-234 Tx Plan | 04/12/201C
Group Rehabilitation | Client Svc | 04/12/2010 | 04/12/2011 | Yes | U-234 Tx Plan | 04/12/201C
Group Treatment | Client Svc | 04/12/2010 | 04/12/2011 | Yes | U-234 Tx Plan | 04/12/201C
Individual Treatment | Client Svc | 04/12/2010 | 04/12/2011 | Yes | U-234 Tx Plan | 04/12/201C
Institutions & IMD | Client Svc | 04/12/2010 | 04/12/2011 | Yes | U-234 Tx Plan | 04/12/201C
MD Assessment Initial/Follow Up | Client Svc | 04/12/2010 | 04/12/2011 | Yes | U-234 Tx Plan | 04/12/201C
Medication Management MD | Client Svc | 04/12/2010 | 04/12/2011 | Yes | U-234 Tx Plan | 04/12/201C
Medication Support - non MD | Client Svc | 04/12/2010 | 04/12/2011 | Yes | U-234 Tx Plan | 04/12/201C
MH Crisis Intervention | Client Svc | 04/12/2010 | 04/12/2011 | Yes | U-234 Tx Plan | 04/12/201C
Prep Rpt Oth Phys/Agency | Client Svc | 04/12/2010 | 04/12/2011 | Yes | U-234 Tx Plan | 04/12/201C
Rehabilitation | Client Svc | 04/12/2010 | 04/12/2011 | Yes | U-234 Tx Plan | 04/12/201C
Review Hosp Rec/Rpts/Lab | Client Svc | 04/12/2010 | 04/12/2011 | Yes | U-234 Tx Plan | 04/12/201C
Treatment Planning/Plan Develop... | Client Svc | 04/12/2010 | 04/12/2011 | Yes | U-234 Tx Plan | 04/12/201C
Save
Save+
Cancel
Report
UDD
Tree
Bookmark
0:00:19
Set: 4

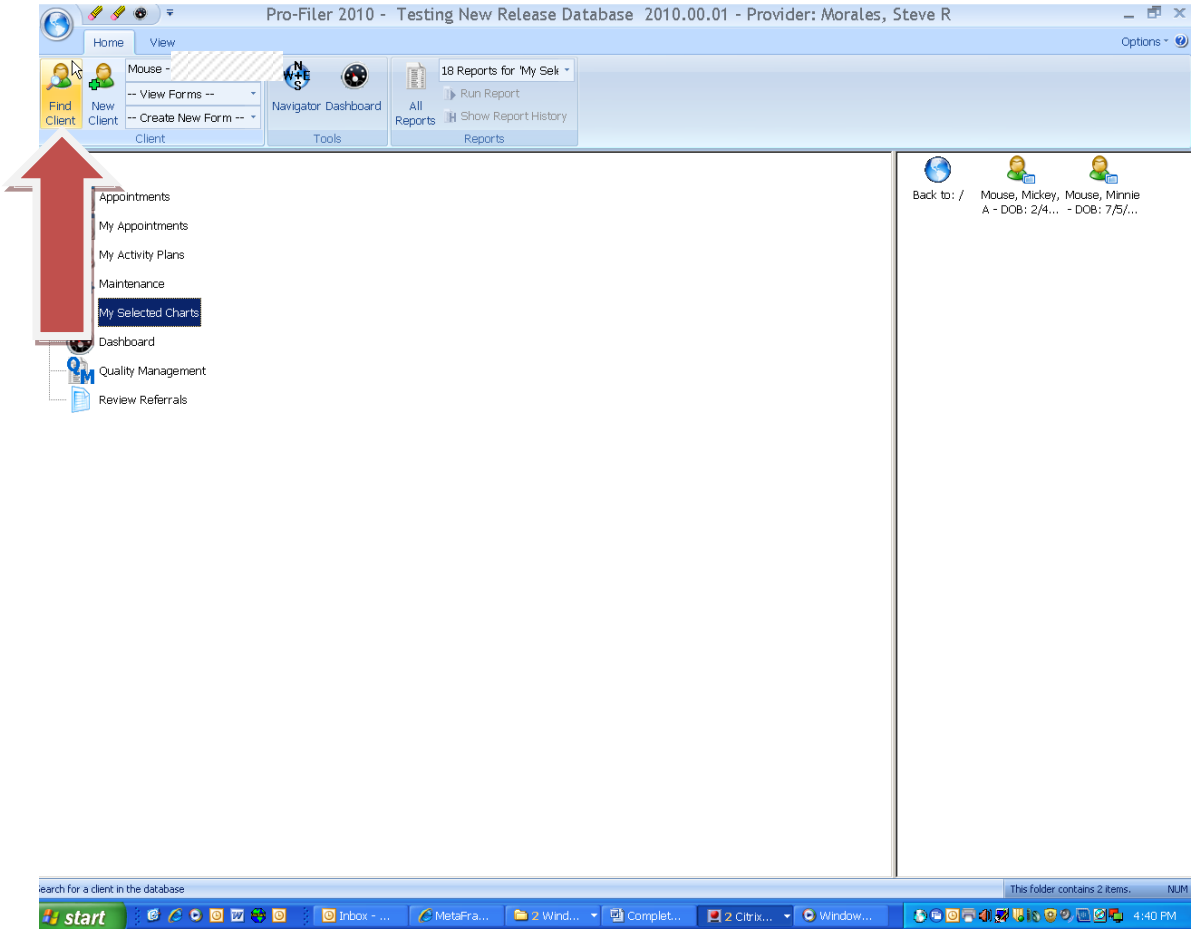
APPENDIX I

USING CASELOAD PROVIDER FROM THE TREE VIEW

Unicare gives you the ability to have a list of all your clients on the Tree View simultaneously.

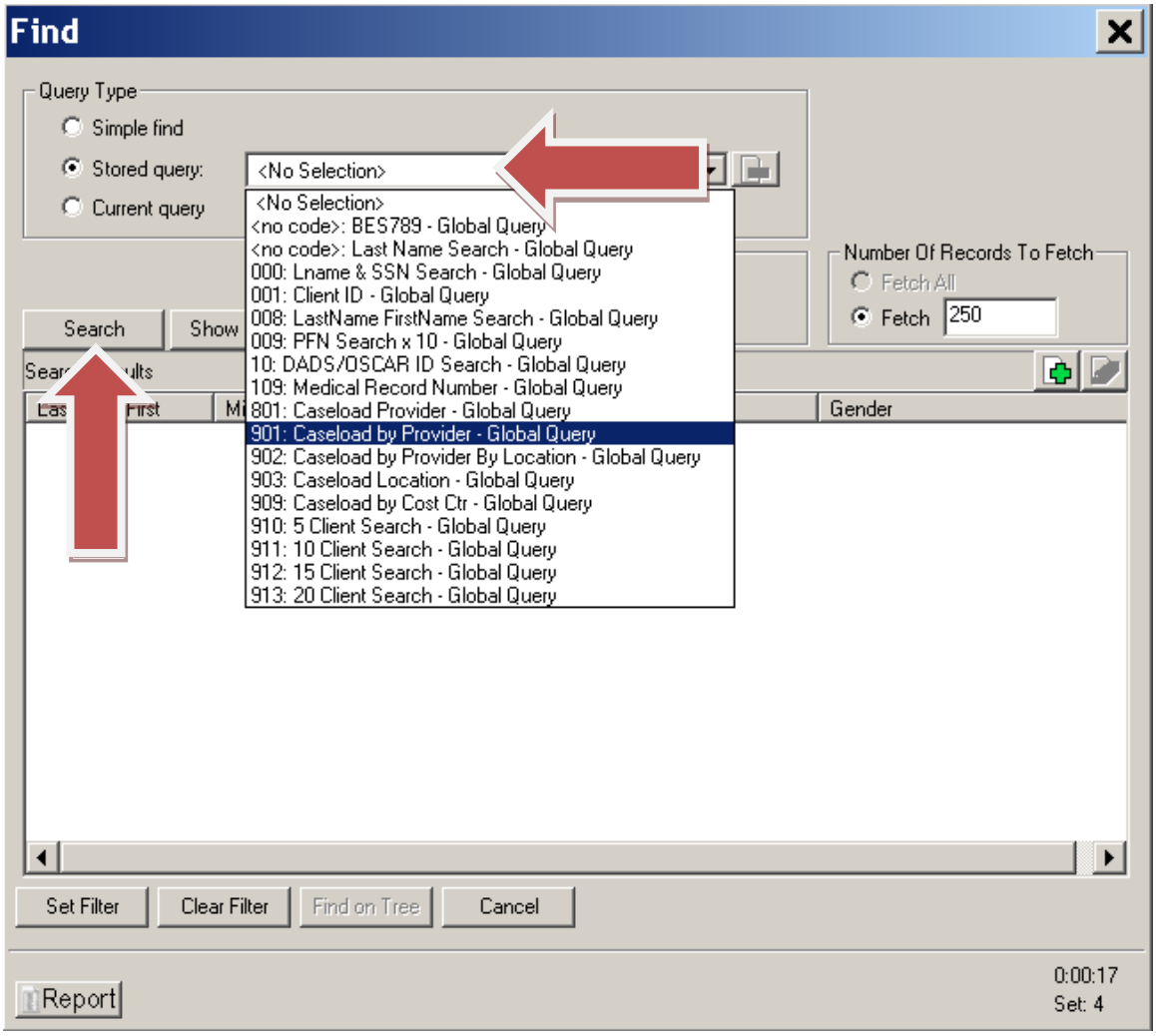
Note: This function does not apply to psychiatrists. Clients are assigned to case managers as the primary providers. This function sorts by primary providers.

Start at the Tree View and click on the **Find Client** icon.



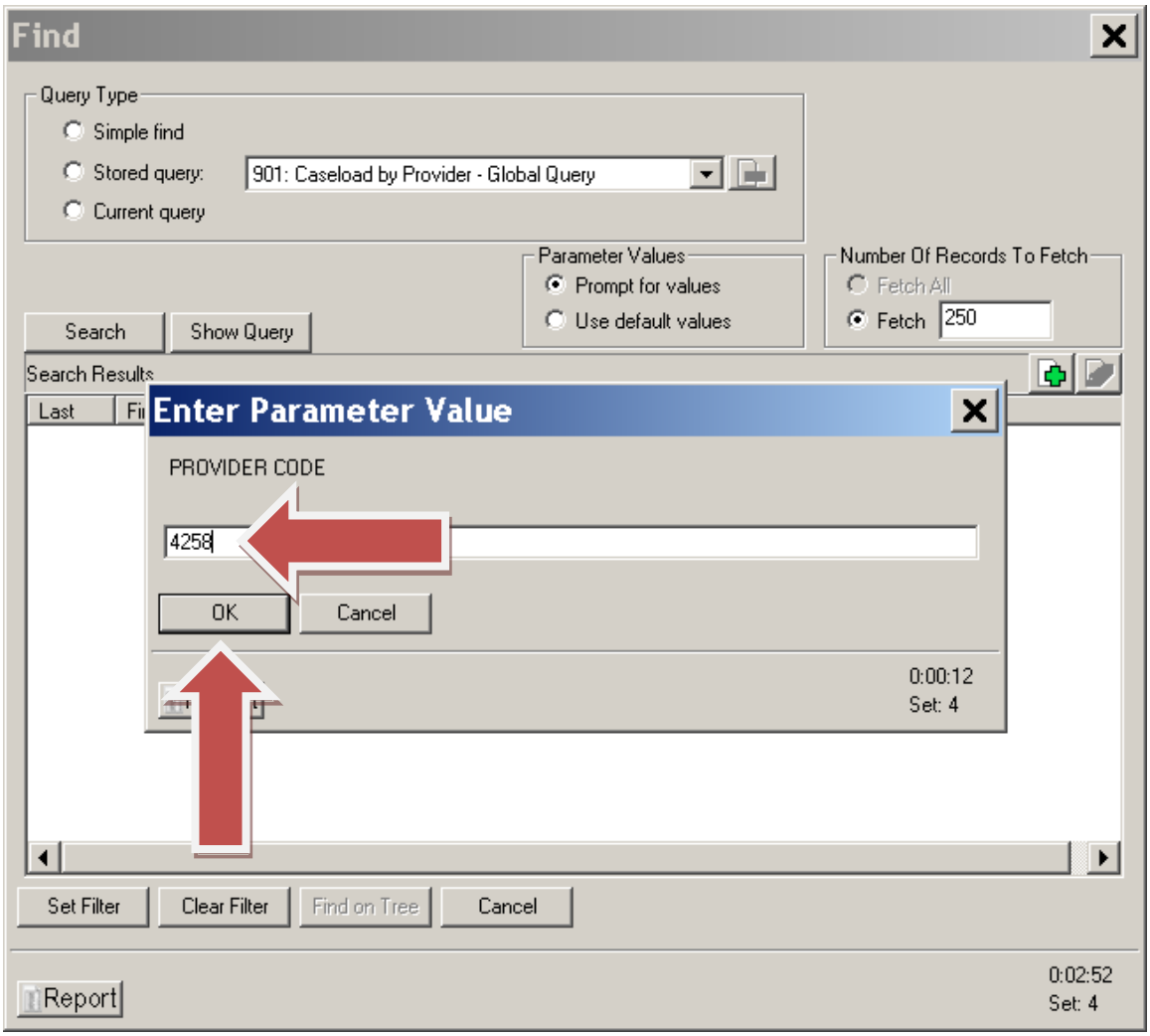
The following screen will be displayed.

1. Click on the drop down menu to the right of Stored Query and choose code **901: Caseload Provider – Global Query**
2. Click **Search**.


Find
Query Type
Simple find
Stored query:
Current query
<No Selection>
<No Selection>
<no code>: BES789 - Global Query
<no code>: Last Name Search - Global Query
000: Lname & SSN Search - Global Query
001: Client ID - Global Query
008: LastName FirstName Search - Global Query
009: PFN Search x 10 - Global Query
10: DADS/OSCAR ID Search - Global Query
109: Medical Record Number - Global Query
801: Caseload Provider - Global Query
901: Caseload by Provider - Global Query
902: Caseload by Provider By Location - Global Query
903: Caseload Location - Global Query
909: Caseload by Cost Ctr - Global Query
910: 5 Client Search - Global Query
911: 10 Client Search - Global Query
912: 15 Client Search - Global Query
913: 20 Client Search - Global Query
Number Of Records To Fetch
Fetch All
Fetch
250
Search
Show
Gender
Set Filter
Clear Filter
Find on Tree
Cancel
Report
0:00:17
Set: 4

The following screen will be displayed.

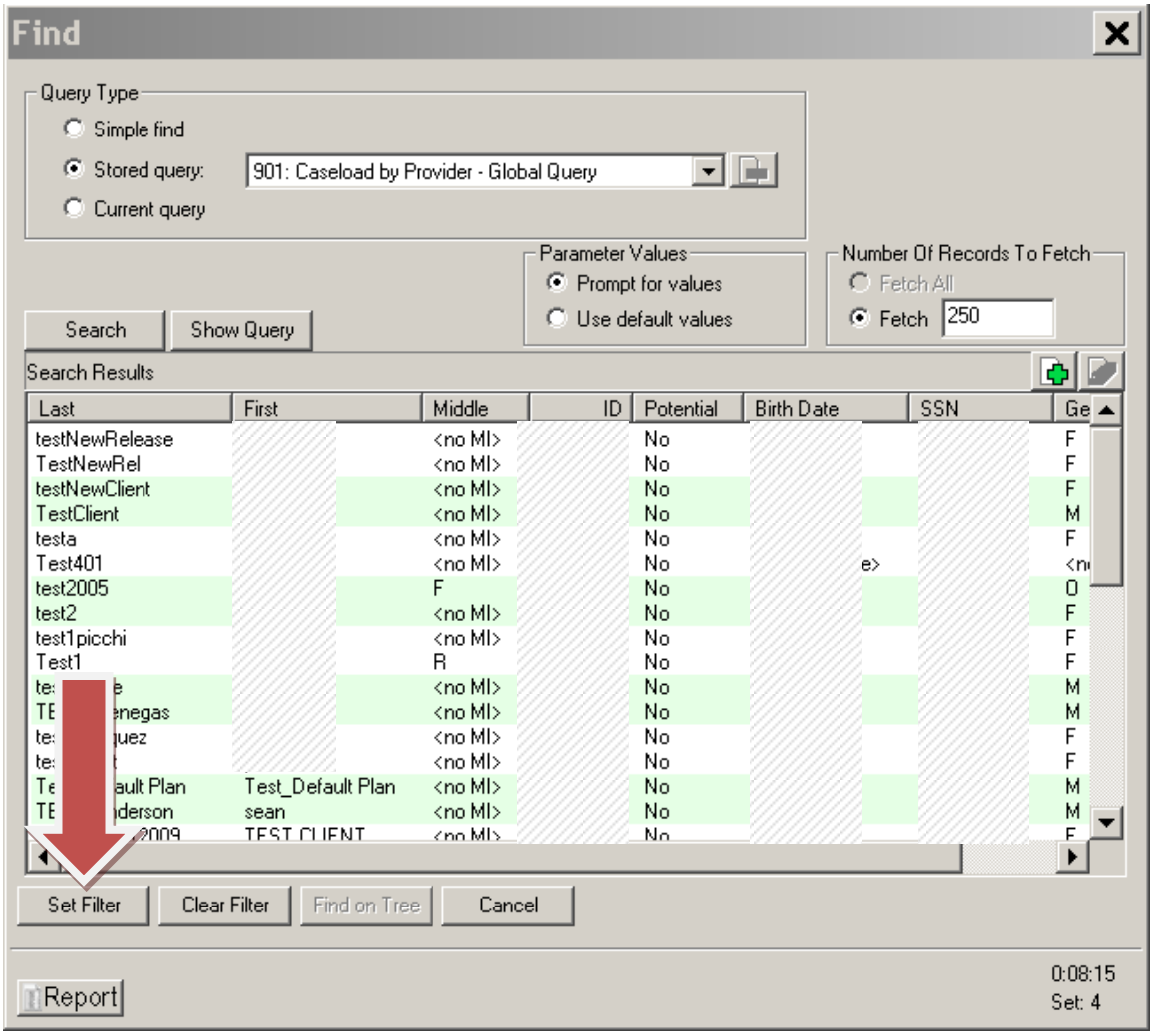
1. Enter your Unicare Provider Code.
2. Click **OK**



The following screen will be displayed.

Your list of clients is now on the screen. Do not highlight them.

Click **Set Filter**. This will put all of the clients listed on your Tree.



The following screen will be displayed.

All of your clients' names are now listed on the Tree View. They will be updated as clients are added and discharged from your provider list.

Note: If the plus sign is displayed to the left of My Selected Charts, click on it to change it to a minus sign and expand the folder.